Subchapter 28

37.86.2801 ALL HOSPITAL REIMBURSEMENT, GENERAL

(1) Reimbursement for inpatient hospital services is set forth in ARM 37.86.2904, 37.86.2905, 37.86.2907, 37.86.2912, 37.86.2914, 37.86.2916, 37.86.2918, 37.86.2920, 37.86.2924, 37.86.2925, and 37.86.2928. Reimbursement for outpatient hospital services is set forth in ARM 37.86.3005. The reimbursement period will be the provider's fiscal year. Cost of hospital services will be determined for inpatient and outpatient care separately. Administratively necessary days are not a benefit of the Montana Medicaid program.

(2) The department may require providers of inpatient or outpatient hospital services to obtain authorization from the department or its designated review organization either prior to provision of services or prior to payment.

(3) Medicaid reimbursement shall not be made unless the provider has obtained authorization from the department or its designated review organization prior to providing any of the following services:

(a) inpatient psychiatric services provided in an acute care general hospital or a distinct part psychiatric unit of an acute care general hospital, as required by ARM 37.88.101;

(b) inpatient rehabilitation services;

(c) except as provided in (4) all inpatient and outpatient hospital services provided in hospitals located more than 100 miles outside the borders of the state of Montana;

(d) services related to organ transplantations covered under ARM 37.86.4701 and 37.86.4705; or

(e) outpatient partial hospitalization, as required by ARM 37.88.101.

(4) Upon the request of a hospital located more than 100 miles outside the borders of the state of Montana, the department may grant retroactive authorization for the provision of the hospital's services under the following circumstances only:

(a) the person to whom services were provided was determined by the department to be retroactively eligible for Montana Medicaid benefits including hospital benefits;

(b) the hospital is retroactively enrolled as a Montana Medicaid provider, and the enrollment includes the dates of service for which authorization is requested; or

(c) the hospital can document that at the time of admission it did not know, or have any basis to assume, that the patient was a Montana Medicaid client. (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA; NEW, 1983 MAR p. 756, Eff. 7/1/83; EMERG, AMD, 1985 MAR p. 1160, Eff. 8/16/85; AMD, 1987 MAR p. 1658, Eff. 10/1/87; AMD, 1991 MAR p. 1027, Eff. 7/1/91; AMD, 1992 MAR p. 1496, Eff. 7/17/92; AMD, 1993 MAR p. 1520, Eff. 7/16/93; AMD, 1994 MAR p. 1732, Eff. 7/1/94; AMD, 1995 MAR p. 1162, Eff. 7/1/95; AMD, 1996 MAR p. 459, Eff. 2/9/96; AMD, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1999 MAR p. 1388, Eff. 6/18/99; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00; AMD, 2001 MAR p. 27, Eff. 1/12/01; EMERG, AMD, 2001 MAR p. 1119, Eff. 6/22/01; AMD, 2002 MAR p. 1991, Eff. 8/1/02; EMERG, AMD, 2003 MAR p. 999, Eff. 5/9/03; AMD, 2003 MAR p. 1652, Eff. 8/1/03; AMD, 2004 MAR p. 482, Eff. 2/27/04; AMD, 2005 MAR p. 265, Eff. 2/11/05.)

Rule 37.86.2802 reserved

37.86.2803 ALL HOSPITAL REIMBURSEMENT, COST REPORTING

(1) Allowable costs will be determined in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants. Such definition of allowable costs is further defined in accordance with the Medicare Provider Reimbursement Manual, CMS Publication 15 last updated April 2005 (Pub. 15), subject to the exceptions and limitations provided in the department's administrative rules. The department adopts and incorporates by reference Pub. 15, which is a manual published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), which provides guidelines and policies to implement Medicare regulations which set forth principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended. A copy of Pub. 15 may be obtained through the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(a) Hospitals located in the state of Montana providing inpatient and outpatient hospital services reimbursement under the retrospective cost based methodology for a hospital that is identified by the department as a distinct part rehabilitation unit are subject to the provisions regarding cost reimbursement and coverage limits and rate of increase ceilings specified in 42 CFR 413.30 through 413.40 (2002), except as otherwise provided in these rules. This provision applies to distinct part rehabilitation units only through January 31, 2003. The department adopts and incorporates by reference 42 CFR 413.30 through 413.40 (2002). A copy of 42 CFR 413.30 through 413.40 (2002) may be obtained through the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(b) For cost report periods ending on or after July 1, 2003, for each hospital which is not a sole community hospital, critical access hospital or exempt hospital as defined in ARM 37.86.2901, reimbursement for reasonable costs of outpatient hospital services, other than the capital-related costs of such services, shall be limited to allowable costs, as determined in accordance with (1), less 5.8% of such costs.

(c) For cost report periods ending on or after July 1, 2003, for each hospital which is a sole community hospital, as defined in ARM 37.86.2901, reimbursement for reasonable costs of outpatient hospital services, other than the capital-related costs of such services, shall be limited to allowable costs, as determined in accordance with (1).

(d) For cost report periods ending on or after January 1, 2006, for each hospital which is a critical access or exempt hospital, as defined in ARM 37.86.2901, reimbursement for reasonable costs of outpatient hospital services shall be limited to 101% of allowable costs, as determined in accordance with (1).

(2) All hospitals reimbursed under ARM 37.86.2904, 37.86.2907, 37.86.2912, 37.86.2914, 37.86.2916, 37.86.2918, 37.86.2920, 37.86.2924, 37.86.2925, or 37.86.3005 must submit, as provided in (3), an annual Medicare cost report in which costs have been allocated to the Medicaid program as they relate to charges. The facility shall maintain appropriate accounting records which will enable the facility to fully complete the cost report.

(3) All hospitals reimbursed under ARM 37.86.2904, 37.86.2905, 37.86.2907, 37.86.2912, 37.86.2914, 37.86.2916, 37.86.2918, 37.86.2920, 37.86.2924, 37.86.2925, or 37.86.3005 must file the cost report with the Montana Medicare intermediary and the department on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period.

(a) Extensions of the due date for filing a cost report may be granted by the intermediary only when a provider's operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire.

(b) In the event a provider does not file a cost report within the time limit or files an incomplete cost report, the provider's total reimbursement will be withheld. All amounts so withheld will be payable to the provider upon submission of a complete and accurate cost report.

(4) For distinct part rehabilitation units identified in ARM 37.86.2901 and 37.86.2916, the base year is the facility's cost report for the first cost reporting period ending after June 30, 1985 that both covers 12 months and includes Montana Medicaid inpatient hospital costs. Exceptions will be granted only as permitted by the applicable provisions of 42 CFR 413.30 or 413.40 (2002). (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-149, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04; AMD, 2006 MAR p. 768, Eff. 3/24/06.)

Rules 37.86.2804 through 37.86.2809 reserved

37.86.2810 INPATIENT AND OUTPATIENT HOSPITAL SERVICES, QUALIFIED RATE ADJUSTMENT PAYMENT, ELIGIBILITY, AND COMPUTATION

(1) The department will pay a qualified rate adjustment (QRA) payment to an eligible rural hospital in Montana for inpatient services or outpatient services or both when:

(a) the hospital's most recently reported costs are greater than the reimbursement received from Montana Medicaid;

(b) the hospital is county owned, county operated, or partially county funded, including tax district funding;

(c) county funds are transferred directly to the department and are certified by the county as match for payment of services eligible for federal financial participation in accordance with 42 CFR 433.51;

(d) the county funds are not federal funds or are federal funds authorized by federal law to be used to match other federal funds; and

(e) the hospital has executed and entered into a written agreement with the department and has agreed to abide by the terms of the written agreement:

(i) the written agreement between the department and the hospital must be executed prior to the issuance of the qualified rate adjustment payment;

(ii) a retroactive effective date on the written agreement shall not be allowed; and

(iii) a hospital that does not enter into a written agreement with the department or does not abide by the terms of the agreement will not be eligible for the qualified rate adjustment payment process.

(2) The qualified rate adjustment payment is subject to the restrictions imposed by federal law, to federal approval of the state plan with respect to qualified rate adjustment and to the availability of sufficient state, county, and federal funding.

(3) The department will calculate the amount of the qualified rate adjustment payment for each eligible rural hospital using the hospital's most recently submitted cost report and paid claims data. The qualified rate adjustment payment for each eligible rural hospital shall be the lesser of:

(a) the amount of county funds transferred to the department plus federal financial participation;

(b) the difference between established Medicaid rates and the upper payment limit (UPL) as set by federal regulation; or

(c) the amount of county match funds to be transferred to the department plus the federal matched funds equal the total QRA payment.

(4) The department will pay the qualified rate adjustment only to hospitals that choose to participate and such payments shall not be subject to the cost settlement process. (History: 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2002 MAR p. 1991, Eff. 7/26/02.)

Rules 37.86.2811 through 37.86.2819 reserved

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37.86.2820 DESK REVIEWS, OVERPAYMENTS, AND UNDERPAYMENTS

(1) Upon receipt of the cost report, the department will instruct the Medicare intermediary to consider Medicaid data when they perform a desk review or audit of the cost report and determine whether a Medicaid overpayment or underpayment has resulted.

(2) Where the department finds that an overpayment has occurred, the department will notify the provider of the overpayment.

(a) In the event of an overpayment, the department will, within 30 days after the day the department notifies the provider that an overpayment exists, arrange to recover the overpayment by set-off against amounts paid for hospital services or by repayments by the provider.

(b) If repayment is not made within 30 days after notification to the provider, the department will make deductions from rate payments with full recovery to be completed within 60 days from the date of the initial request for payment. Recovery will be undertaken even though the provider disputes in whole or in part the department's determination of the overpayment and requests a fair hearing.

(3) In the event an underpayment has occurred, the department will reimburse the provider within 30 days following the department's determination of the amount.

(a) The amount of any overpayment constitutes a debt due the department as of the date of initial request for payment and may be recovered from any person, party, transferee, or fiduciary who has benefited from either the payment or from a transfer of assets.

(4) Providers aggrieved by adverse determinations by the department may request an administrative review and fair hearing as provided in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334, 37.5.337. (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04.)

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Subchapter 29

Inpatient Hospital Services

37.86.2901 INPATIENT HOSPITAL SERVICES, DEFINITIONS

(1) "Administratively necessary days" or "inappropriate level of care services" means those services for which alternative placement of a patient is planned and/or effected and for which there is no medical necessity for acute level inpatient hospital care.

(2) "Border hospital" means a hospital located outside Montana, but no more than 100 miles from the border.

(3) "Cost outlier" means an unusually high cost case that exceeds the cost outlier thresholds as set forth in ARM 37.86.2916.

(4) "Critical access hospital" means a limited-service rural hospital licensed by the Montana Department of Public Health and Human Services.

(5) "Direct nursing care" means the care given directly to the patient which requires the skills and expertise of an RN or LPN.

(6) "Discharging hospital" means a hospital, other than a transferring hospital, that formally discharges an inpatient. Release of a patient to another hospital, as described in (21) or a leave of absence from the hospital will not be recognized as a discharge. A patient who dies in the hospital is considered a discharge.

(7) "Distinct part rehabilitation unit" means a unit of an acute care general hospital that meets the requirements in 42 CFR 412.25 and 412.29 (1992).

(8) "DRG hospital" means a hospital reimbursed pursuant to the diagnosis related group (DRG) system. DRG hospitals are classified as such by the Centers for Medicare and Medicaid Services (CMS) in accordance with 42 CFR 412.

(9) "Exempt hospital" means, for purposes of determining whether a hospital is exempt from the prospective payment system under ARM 37.86.2905, an acute care hospital that is located in a Montana county designated on or before July 1, 1991 as continuum code 8 or continuum code 9 by the United States Department of Agriculture under its rural-urban continuum codes for metro and nonmetro counties.

(10) "Hospital reimbursement adjustor" (HRA) means a payment to a Montana hospital as specified in ARM 37.86.2928 and 37.86.2940.

(11) "Hospital resident" means a recipient who is unable to be cared for in a setting other than the acute care hospital as provided in ARM 37.86.2921.

(12) "Inpatient" means a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person generally is considered an inpatient if formally admitted as an inpatient with an expectation that the patient will remain more than 24 hours. The physician or other practitioner is responsible for deciding whether the patient should be admitted as an inpatient. Inpatient hospital admissions are subject to retrospective review by the Medicaid peer review organization (PRO) to determine whether the inpatient admission was medically necessary for Medicaid payment purposes.

(13) "Inpatient hospital services" means services that are ordinarily furnished in a hospital for the care and treatment of an inpatient under the direction of a physician, dentist, or other practitioner as permitted by federal law, and that are furnished in an institution that:

(a) is maintained primarily for the care and treatment of patients with disorders other than:

(i) tuberculosis; or

(ii) mental diseases, except as provided in (12)(d);

(b) is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located;

(c) except as otherwise permitted by federal law, meets the requirements for participation in Medicare as a hospital and has in effect a utilization review plan that meets the requirements of 42 CFR 482.30; or

(d) provides inpatient psychiatric hospital services for individuals under age 21 pursuant to ARM Title 37, chapter 88, subchapter 11.

(14) "Large referral hospital" means an acute care hospital located in the state of Montana that serves as a referral center and has been determined by the department as of April 1, 1993 to have a case mix with a statistically demonstrated level of intensity of care which is higher than the norm for Montana acute care hospitals. Such facilities are Benefis Health Care (Great Falls), Deaconess Medical Center (Billings), Community Medical Center (Missoula), St. James Hospital (Butte), St. Patrick's Hospital (Missoula) and St. Vincent's Hospital (Billings).

(15) "Low income utilization rate" means a hospital's percentage rate as specified in ARM 37.86.2935.

(16) "Medicaid inpatient utilization rate" means a hospital's percentage rate as specified in ARM 37.86.2932.

(17) "Qualified rate adjustment payment" (QRA) means an additional payment as provided in ARM 37.86.2910 to a county owned, county operated, or partially county funded rural hospital in Montana where the hospital's most recently reported costs are greater than the reimbursement received from Montana Medicaid for inpatient care.

(18) "Routine disproportionate share hospital" means a hospital in Montana which meets the criteria of ARM 37.86.2931.

(19) "Rural hospital" means for purposes of determining disproportionate share hospital payments, an acute care hospital that is located within a "rural area" as defined in 42 CFR 412.62(f)(iii).

(20) "Sole community hospital" means a DRG reimbursed hospital classified as such by the Centers for Medicare and Medicaid Services (CMS) in accordance with 42 CFR 412.92(a) through (d) and/or hospitals with less than 51 beds.

(21) "Supplemental disproportionate share hospital" means a hospital in Montana which meets the criteria in ARM 37.86.2925.

(22) "Transferring hospital" means a hospital that formally releases an inpatient to another inpatient hospital or inpatient unit of a hospital.

(23) "Urban hospital" means an acute care hospital that is located within a metropolitan statistical area, as defined in 42 CFR 412.62(f)(2). (History: 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, 53-6-149, MCA; NEW, Eff. 11/4/74; AMD, 1983 MAR p. 756, Eff. 7/1/83; AMD, 1987 MAR p. 1658, Eff. 10/1/87; AMD, 1988 MAR p. 1199, Eff. 7/1/88; AMD, 1988 MAR p. 2570, Eff. 12/9/88; AMD, 1991 MAR p. 198, Eff. 2/15/91; AMD, 1991 MAR p. 310, Eff. 3/15/91; AMD, 1991 MAR p. 1025, Eff. 7/1/91; AMD, 1993 MAR p. 1520, Eff. 7/16/93; AMD, 1994 MAR p. 1732, Eff. 7/1/94; AMD, 1995 MAR p. 1162, Eff. 7/1/95; AMD, 1996 MAR p. 3218, Eff. 12/20/96; AMD, 1997 MAR p. 1209, Eff. 7/8/97; AMD, 1999 MAR p. 1388, Eff. 6/18/99; AMD, 1999 MAR p. 2078, Eff. 9/24/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1666, Eff. 6/30/00; AMD, 2000 MAR p. 2034, Eff. 7/28/00; AMD, 2001 MAR p. 1119, Eff. 6/22/01; AMD, 2002 MAR p. 1991, Eff. 8/1/02; AMD, 2003 MAR p. 1652, Eff. 8/1/03; AMD, 2004 MAR p. 482, Eff. 2/27/04; AMD, 2005 MAR p. 265, Eff. 2/11/05.)

37.86.2902 INPATIENT HOSPITAL SERVICES, REQUIREMENTS

(1) These requirements are in addition to those contained in rule provisions generally applicable to Medicaid providers.

(2) Except as otherwise permitted by federal law, inpatient hospital services must be ordered by a physician or dentist licensed under state law.

(3) Inpatient hospital services include:

(a) bed and board;

(b) nursing services and other related services;

(c) use of hospital facilities;

(d) medical social services;

(e) drugs, biologicals, supplies, appliances, and equipment;

(f) other diagnostic or therapeutic items, or services provided in the hospital and not specifically excluded in ARM 37.85.207;

(g) medical or surgical services provided by interns or residents-in-training in hospitals with teaching programs approved by the Council on Medical Education of the American Medical Association, the Bureau of Professional Education of the American Osteopathic Association, the Council on Dental Education of the American Dental Association or the Council on Podiatry Education of the American Podiatry Association.

(4) Alcohol and drug treatment services are limited to:

(a) detoxification services up to four days, except that more than four days may be covered if concurrently authorized by the designated review organization and a hospital setting is required; or

(b) the designated review organization determines that the patient has a concomitant condition that must be treated in the inpatient hospital setting, and the alcohol and drug treatment is a necessary adjunct to the treatment of the concomitant condition.

(5) Inpatient hospital services provided outside the borders of the United States will not be reimbursed by the Montana Medicaid program. (History: 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA; NEW, 1983 MAR p. 756, Eff. 7/1/83; AMD, 1987 MAR p. 905, Eff. 7/1/87; AMD, 1987 MAR p. 2168, Eff. 11/28/87; AMD, 1989 MAR p. 281, Eff. 2/10/89; AMD, 1993 MAR p. 1520, Eff. 7/16/93; AMD, 1994 MAR p. 1732, Eff. 7/1/94; AMD, 1995 MAR p. 1162, Eff. 7/1/95; AMD, 1999 MAR p. 2078, Eff. 9/24/99; TRANS, from SRS, 2000 MAR p. 481.)

Rule 37.86.2903 reserved

37.86.2904 INPATIENT HOSPITAL SERVICES, BILLING REQUIREMENTS

(1) Inpatient hospital service providers shall be subject to the billing requirements set forth in ARM 37.85.406. At the time a claim is submitted, the hospital must have on file a signed and dated acknowledgment from the attending physician that the physician has received the following notice: "Notice to physicians: Medicaid payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment or civil penalty under applicable federal laws."

(2) The acknowledgment must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient to the hospital.

(3) Existing acknowledgments signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

(4) The provider may, at its discretion, add to the language of this statement the word "Medicare" so that two separate forms will not be required by the provider to comply with both state and federal requirements.

(5) Except for hospital resident cases, a provider may not submit a claim until the recipient has been either:

(a) discharged from the hospital;

(b) transferred to another hospital; or

(c) designated by the department as a hospital resident as set forth in ARM 37.86.2901.

(6) The Medicaid statewide average cost to charge ratio excluding capital expenses is 56%. (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04.)

37.86.2905 INPATIENT HOSPITAL SERVICES, GENERAL REIMBURSEMENT (1) Except as provided in (2), which is applicable to exempt hospitals and critical access hospitals (CAH), in-state inpatient hospital service providers, including inpatient rehabilitation services and services in a setting that is identified by the department as a distinct rehabilitation unit, will be reimbursed under the DRG prospective payment system described in ARM 37.86.2907, 37.86.2912, 37.86.2914, 37.86.2916, 37.86.2918, 37.86.2920, and 37.86.2924.

(2) Exempt hospital and CAH interim reimbursement is based on a hospital specific Medicaid inpatient cost to charge ratio, not to exceed 100%. Exempt hospitals and CAHs will be reimbursed their actual allowable costs determined according to ARM 37.86.2803.

(3) Except as otherwise specified in these rules, facilities reimbursed under the DRG prospective payment system may be reimbursed, in addition to the prospective DRG rate, for the following:

(a) capital-related costs as set forth in ARM 37.86.2912;

(b) medical education costs as set forth in ARM 37.86.2914;

(c) cost outliers as set forth in ARM 37.86.2916;

(d) readmissions and transfers, as set forth in ARM 37.86.2918;

(e) hospital residents, as set forth in ARM 37.86.2920;

(f) disproportionate share hospital payments as provided in ARM 37.86.2925;

(g) certified registered nurse anesthetist costs as provided in ARM 37.86.2924;

(h) qualified rate adjustor payments, as set forth in ARM 37.86.2910; and

(i) hospital reimbursement adjustor payments as provided in ARM 37.86.2928. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA; NEW, 1987 MAR p. 1658, Eff. 10/1/87; AMD, 1987 MAR p. 1804, Eff. 10/16/87; AMD, 1988 MAR p. 1199, Eff. 7/1/88; AMD, 1988 MAR p. 2570, Eff. 12/9/88; AMD, 1989 MAR p. 864, Eff. 6/30/89; AMD, 1989 MAR p. 1848, Eff. 11/10/89; AMD, 1990 MAR p. 1588, Eff. 8/17/90; AMD, 1991 MAR p. 310, Eff. 3/15/91; AMD, 1991 MAR p. 1025, Eff. 7/1/91; AMD, 1993 MAR p. 1520, Eff. 7/16/93; AMD, 1994 MAR p. 1732, Eff. 7/1/94; AMD, 1995 MAR p. 1162, Eff. 7/1/95; AMD, 1996 MAR p. 459, Eff. 2/9/96; AMD, 1996 MAR p. 1682, Eff. 6/21/96; AMD, 1997 MAR p. 1209, Eff. 7/8/97; AMD, 1998 MAR p. 2168, Eff. 8/14/98; AMD, 1999 MAR p. 1388, Eff. 6/18/99; AMD, 1999 MAR p. 2078, Eff. 9/24/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1666, Eff. 6/30/00; AMD, 2000 MAR p. 2034, Eff. 7/28/00; EMERG, AMD, 2001 MAR p. 1119, Eff. 6/22/01; AMD, 2002 MAR p. 797, Eff. 3/15/02; EMERG, AMD, 2002 MAR p. 1991, Eff. 8/1/02; AMD, 2002 MAR p. 2665, Eff. 9/27/02; EMERG, AMD, 2003 MAR p. 999, Eff. 5/9/03; AMD, 2003 MAR p. 1652, Eff. 8/1/03; AMD, 2004 MAR p. 482, Eff. 2/27/04; AMD, 2005 MAR p. 265, Eff. 2/11/05.)

Rule 37.86.2906 reserved

37.86.2907 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, DRG PAYMENT RATE DETERMINATION (1) The department's DRG prospective payment rate for inpatient hospital services is based on the classification of inpatient hospital discharges to DRGs. The procedure for determining the DRG prospective payment rate is as follows:

(a) Prior to October 1st of each year, the department will assign a DRG to each Medicaid patient discharge in accordance with the current Medicare grouper program version, as developed by 3M Health Information Systems. The assignment of each DRG is based on:

(i) the ICD-9-CM principal diagnoses;

(ii) the ICD-9-CM secondary diagnoses;

(iii) the ICD-9-CM medical procedures performed during the recipient's hospital stay;

(iv) the recipient's age;

(v) the recipient's sex; and

(vi) the recipient's discharge status.

(b) For each DRG, the department determines a relative weight, depending upon whether or not the hospital is a large referral hospital, which reflects the cost of hospital resources used to treat cases in that DRG relative to the statewide average cost of all Medicaid hospital cases. The relative weight for each DRG is available upon request from Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(c) The department computes a Montana average base price per case. This average base price per case is $1980 excluding capital expenses, effective for services provided on or after August 1, 2003.

(d) The relative weight for the assigned DRG is multiplied by the average base price per case to compute the DRG prospective payment rate for that Medicaid patient discharge except where there is no weight assigned to a DRG. Referred to as "exempt", the unweighted DRG will be paid at the statewide cost to charge ratio as defined in ARM 37.86.2904.

(2) For those Montana hospitals designated by the department after July 15, 2005 as having met the requirements for a specialty (level II) and subspecialty (level III) neonatal intensive care facility as provided in the Guidelines for Perinatal Care, Fifth Edition (2002), published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, reimbursement for neonatal DRGs 385 through 389 will be actual allowable cost determined on a retrospective basis, with allowable costs determined according to ARM 37.86.2803. The guidelines are adopted and incorporated by reference and are available through the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. In addition, such facilities:

(a) will be reimbursed on an interim basis during each facility's fiscal year. The interim rate will be a percentage of usual and customary charges, and the percentage will be the facility-specific cost to charge ratio, determined by the department in accordance with Medicare reimbursement principles.

(b) may split bill when total charges reach $100,000. The first interim split bill must total at least $100,000 in charges.

(c) will not receive any cost outlier payment or other add-on payment with respect to such discharges or services.

(3) The Montana Medicaid DRG relative weight values, average length of stay (ALOS), and outlier thresholds are contained in the DRG table of weights and thresholds (October 2005). The DRG Table of Weights and Thresholds is published by the department. The department adopts and incorporates by reference the DRG Table of Weights and Thresholds (October 2005). Copies may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04; AMD, 2005 MAR p. 265, Eff. 2/11/05; AMD, 2006 MAR p. 768, Eff. 3/24/06.)

Rules 37.86.2908 and 37.86.2909 reserved

37.86.2910 INPATIENT HOSPITAL REIMBURSEMENT, QUALIFIED RATE ADJUSTMENT PAYMENT (1) Subject to the availability of sufficient county and federal funding, restrictions imposed by federal law, and the approval of the state plan by the Centers for Medicare and Medicaid Services (CMS), the department will pay, in addition to the Medicaid payments provided for in ARM 37.86.2904, 37.86.2905, 37.86.2907, 37.86.2912, 37.86.2914, 37.86.2916, 37.86.2918, 37.86.2920, 37.86.2924, 37.86.2925, and 37.86.2928 a qualified rate adjustment payment to an eligible county owned, operated, or partially county funded rural hospital in Montana as provided in ARM 37.86.2810. (History: 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2000 MAR p. 2034, Eff. 7/28/00; AMD, 2001 MAR p. 1119, Eff. 6/22/01; AMD, 2002 MAR p. 1991, Eff. 8/1/02; AMD, 2004 MAR p. 482, Eff. 2/27/04.)

Rule 37.86.2911 reserved

37.86.2904 INPATIENT HOSPITAL SERVICES, BILLING REQUIREMENTS

(1) Inpatient hospital service providers shall be subject to the billing requirements set forth in ARM 37.85.406. At the time a claim is submitted, the hospital must have on file a signed and dated acknowledgment from the attending physician that the physician has received the following notice: "Notice to physicians: Medicaid payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment or civil penalty under applicable federal laws."

(2) The acknowledgment must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient to the hospital.

(3) Existing acknowledgments signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

(4) The provider may, at its discretion, add to the language of this statement the word "Medicare" so that two separate forms will not be required by the provider to comply with both state and federal requirements.

(5) Except for hospital resident cases, a provider may not submit a claim until the recipient has been either:

(a) discharged from the hospital;

(b) transferred to another hospital; or

(c) designated by the department as a hospital resident as set forth in ARM 37.86.2901.

(6) The Medicaid statewide average cost to charge ratio excluding capital expenses is 56%. (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04.)

37.86.2905 INPATIENT HOSPITAL SERVICES, GENERAL REIMBURSEMENT (1) Except as provided in (2), which is applicable to exempt hospitals and critical access hospitals (CAH), in-state inpatient hospital service providers, including inpatient rehabilitation services and services in a setting that is identified by the department as a distinct rehabilitation unit, will be reimbursed under the DRG prospective payment system described in ARM 37.86.2907, 37.86.2912, 37.86.2914, 37.86.2916, 37.86.2918, 37.86.2920, and 37.86.2924.

(2) Exempt hospital and CAH interim reimbursement is based on a hospital specific Medicaid inpatient cost to charge ratio, not to exceed 100%. Exempt hospitals and CAHs will be reimbursed their actual allowable costs determined according to ARM 37.86.2803.

(3) Except as otherwise specified in these rules, facilities reimbursed under the DRG prospective payment system may be reimbursed, in addition to the prospective DRG rate, for the following:

(a) capital-related costs as set forth in ARM 37.86.2912;

(b) medical education costs as set forth in ARM 37.86.2914;

(c) cost outliers as set forth in ARM 37.86.2916;

(d) readmissions and transfers, as set forth in ARM 37.86.2918;

(e) hospital residents, as set forth in ARM 37.86.2920;

(f) disproportionate share hospital payments as provided in ARM 37.86.2925;

(g) certified registered nurse anesthetist costs as provided in ARM 37.86.2924;

(h) qualified rate adjustor payments, as set forth in ARM 37.86.2910; and

(i) hospital reimbursement adjustor payments as provided in ARM 37.86.2928. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA; NEW, 1987 MAR p. 1658, Eff. 10/1/87; AMD, 1987 MAR p. 1804, Eff. 10/16/87; AMD, 1988 MAR p. 1199, Eff. 7/1/88; AMD, 1988 MAR p. 2570, Eff. 12/9/88; AMD, 1989 MAR p. 864, Eff. 6/30/89; AMD, 1989 MAR p. 1848, Eff. 11/10/89; AMD, 1990 MAR p. 1588, Eff. 8/17/90; AMD, 1991 MAR p. 310, Eff. 3/15/91; AMD, 1991 MAR p. 1025, Eff. 7/1/91; AMD, 1993 MAR p. 1520, Eff. 7/16/93; AMD, 1994 MAR p. 1732, Eff. 7/1/94; AMD, 1995 MAR p. 1162, Eff. 7/1/95; AMD, 1996 MAR p. 459, Eff. 2/9/96; AMD, 1996 MAR p. 1682, Eff. 6/21/96; AMD, 1997 MAR p. 1209, Eff. 7/8/97; AMD, 1998 MAR p. 2168, Eff. 8/14/98; AMD, 1999 MAR p. 1388, Eff. 6/18/99; AMD, 1999 MAR p. 2078, Eff. 9/24/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1666, Eff. 6/30/00; AMD, 2000 MAR p. 2034, Eff. 7/28/00; EMERG, AMD, 2001 MAR p. 1119, Eff. 6/22/01; AMD, 2002 MAR p. 797, Eff. 3/15/02; EMERG, AMD, 2002 MAR p. 1991, Eff. 8/1/02; AMD, 2002 MAR p. 2665, Eff. 9/27/02; EMERG, AMD, 2003 MAR p. 999, Eff. 5/9/03; AMD, 2003 MAR p. 1652, Eff. 8/1/03; AMD, 2004 MAR p. 482, Eff. 2/27/04; AMD, 2005 MAR p. 265, Eff. 2/11/05.)

Rule 37.86.2906 reserved

37.86.2907 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, DRG PAYMENT RATE DETERMINATION (1) The department's DRG prospective payment rate for inpatient hospital services is based on the classification of inpatient hospital discharges to DRGs. The procedure for determining the DRG prospective payment rate is as follows:

(a) Prior to October 1st of each year, the department will assign a DRG to each Medicaid patient discharge in accordance with the current Medicare grouper program version, as developed by 3M Health Information Systems. The assignment of each DRG is based on:

(i) the ICD-9-CM principal diagnoses;

(ii) the ICD-9-CM secondary diagnoses;

(iii) the ICD-9-CM medical procedures performed during the recipient's hospital stay;

(iv) the recipient's age;

(v) the recipient's sex; and

(vi) the recipient's discharge status.

(b) For each DRG, the department determines a relative weight, depending upon whether or not the hospital is a large referral hospital, which reflects the cost of hospital resources used to treat cases in that DRG relative to the statewide average cost of all Medicaid hospital cases. The relative weight for each DRG is available upon request from Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(c) The department computes a Montana average base price per case. This average base price per case is $1980 excluding capital expenses, effective for services provided on or after August 1, 2003.

(d) The relative weight for the assigned DRG is multiplied by the average base price per case to compute the DRG prospective payment rate for that Medicaid patient discharge except where there is no weight assigned to a DRG. Referred to as "exempt", the unweighted DRG will be paid at the statewide cost to charge ratio as defined in ARM 37.86.2904.

(2) For those Montana hospitals designated by the department after July 15, 2005 as having met the requirements for a specialty (level II) and subspecialty (level III) neonatal intensive care facility as provided in the Guidelines for Perinatal Care, Fifth Edition (2002), published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, reimbursement for neonatal DRGs 385 through 389 will be actual allowable cost determined on a retrospective basis, with allowable costs determined according to ARM 37.86.2803. The guidelines are adopted and incorporated by reference and are available through the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. In addition, such facilities:

(a) will be reimbursed on an interim basis during each facility's fiscal year. The interim rate will be a percentage of usual and customary charges, and the percentage will be the facility-specific cost to charge ratio, determined by the department in accordance with Medicare reimbursement principles.

(b) may split bill when total charges reach $100,000. The first interim split bill must total at least $100,000 in charges.

(c) will not receive any cost outlier payment or other add-on payment with respect to such discharges or services.

(3) The Montana Medicaid DRG relative weight values, average length of stay (ALOS), and outlier thresholds are contained in the DRG table of weights and thresholds (October 2005). The DRG Table of Weights and Thresholds is published by the department. The department adopts and incorporates by reference the DRG Table of Weights and Thresholds (October 2005). Copies may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04; AMD, 2005 MAR p. 265, Eff. 2/11/05; AMD, 2006 MAR p. 768, Eff. 3/24/06.)

Rules 37.86.2908 and 37.86.2909 reserved

37.86.2910 INPATIENT HOSPITAL REIMBURSEMENT, QUALIFIED RATE ADJUSTMENT PAYMENT (1) Subject to the availability of sufficient county and federal funding, restrictions imposed by federal law, and the approval of the state plan by the Centers for Medicare and Medicaid Services (CMS), the department will pay, in addition to the Medicaid payments provided for in ARM 37.86.2904, 37.86.2905, 37.86.2907, 37.86.2912, 37.86.2914, 37.86.2916, 37.86.2918, 37.86.2920, 37.86.2924, 37.86.2925, and 37.86.2928 a qualified rate adjustment payment to an eligible county owned, operated, or partially county funded rural hospital in Montana as provided in ARM 37.86.2810. (History: 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2000 MAR p. 2034, Eff. 7/28/00; AMD, 2001 MAR p. 1119, Eff. 6/22/01; AMD, 2002 MAR p. 1991, Eff. 8/1/02; AMD, 2004 MAR p. 482, Eff. 2/27/04.)

Rule 37.86.2911 reserved

37.86.2912 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, CAPITAL-RELATED COSTS (1) The department will reimburse inpatient hospital service providers located in the state of Montana for capital-related costs that are allowable under Medicare cost reimbursement principles as set forth at 42 CFR 412.113(a), as amended through October 1, 2004. The department adopts and incorporates by reference 42 CFR 412.113(a) and (b), as amended through October 1, 2004, which set forth Medicare cost reimbursement principles. Copies of the cited regulation may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) Prior to settlement based on audited costs, the department will make interim payments for each facility's capital-related costs as follows:

(a) The department will identify the facility's total allowable Medicaid inpatient capital-related costs from the facility's most recent audited or desk reviewed cost report. These costs will be used as a base amount for interim payments. The base amount may be revised if the provider can demonstrate an increase in capital-related costs as a result of an approved certificate of need that is not reflected in the base amount.

(b) All border hospitals that are reimbursed under the DRG prospective payment system will be paid the statewide average capital cost per case as an interim capital-related cost payment. The statewide average capital cost per case is $229. This rate shall be the final capital-related cost with respect to which the department waives retrospective cost settlement in accordance with these rules.

(c) The department will make interim capital payments with each inpatient hospital claim paid. (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04; AMD, 2006 MAR p. 768, Eff. 3/24/06.)

Rule 37.86.2913 reserved

37.86.2914 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, MEDICAL EDUCATION COSTS (1) The department shall reimburse inpatient hospital service providers for medical education related costs that are allowable under Medicare cost reimbursement principles as set forth at 42 CFR 412.113(b), as amended through October 1, 1992.

(2) Prior to settlement based on audited costs, the department shall make interim payments for each facility's medical education related costs as follows:

(a) The department shall identify the facility's total allowable Medicaid inpatient medical education related costs from the facility's most recent audited cost report. These costs will be used as a base amount for interim payments.

(b) The department will make interim medical education related cost reimbursement payments with each inpatient hospital claim paid. (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04.)

Rule 37.86.2915 reserved

37.86.2916 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, COST OUTLIERS (1) In addition to the DRG payment, providers reimbursed under the DRG prospective payment system may receive payment as provided in this rule for cost outliers for DRGs other than neonatal DRGs 385 through 389 provided by neonatal intensive care units described in ARM 37.86.2907.

(2) To receive payment for a cost outlier, the combined cost of the medically necessary days and services of the inpatient hospital stay, as determined by the department, must exceed the cost outlier threshold established by the department for the DRG.

(3) The department determines the outlier reimbursement for cost outliers for all hospitals and distinct part units, entitled to receive cost outlier reimbursement, as follows:

(a) computing an estimated cost for the inpatient hospital stay by multiplying the allowed charges for the stay by the statewide Medicaid cost to charge ratio set forth in ARM 37.86.2904;

(b) subtracting the cost outlier threshold amount from the estimated costs to compute the cost outlier amount; and

(c) multiplying the cost outlier amount by 60% to establish the marginal cost outlier payment for the hospital stay. (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04.)

Rule 37.86.2917 reserved

37.86.2918 INPATIENT HOSPITAL, READMISSIONS, AND TRANSFERS

(1) This rule states the billing requirements applicable to inpatient hospital readmissions and transfers. Sections (2) and (3) apply to DRG hospitals only unless otherwise noted. Sections (4) and (5) apply to DRG, out-of-state and border hospitals.

(2) All readmissions occurring within 30 days will be subject to review to determine whether additional payment as a new DRG or as an outlier is warranted. As a result of the readmission review, the following payment changes will be made:

(a) If it is determined that complications have arisen because of premature discharge and/or other treatment errors, then the DRG payment for the first admission must be altered by combining the two admissions into one for payment purposes; or

(b) If it is determined that the readmission is for the treatment of conditions that could or should have been treated during the previous admission, the department will combine the two admissions into one for payment purposes.

(c) A patient readmission occurring in an inpatient rehabilitation hospital within 72 hours of discharge must be combined into one admission for payment purposes, with the exception of discharge to an acute care hospital for surgical DRGs.

(d) All diagnostic services are included in the DRG payment. Diagnostic services that are performed at a second hospital because the services are not available at the first hospital (e.g., a CT scan) are included in the first hospital's DRG payment. This includes transportation to the second hospital and back to the first hospital. Arrangement for payment to the transportation provider and the second hospital where the services were actually performed must be between the first and second hospital and the transportation provider.

(3) A transfer, for the purpose of this rule, is limited to those instances in which a patient is transferred for continuation of medical treatment between two hospitals, one of which is paid under the Montana Medicaid prospective payment system.

(a) A transferring hospital reimbursed under the DRG prospective payment system is paid for the services and items provided to the transferred recipient, the lesser of:

(i) a per diem rate of two times the average per diem amount for the first inpatient day plus one per diem payment for each subsequent day of inpatient care determined by dividing the sum of the DRG payment for the case as computed in ARM 37.86.2907 and the appropriate outlier as computed in ARM 37.86.2916, if any, by the statewide average length of stay for the DRG; or

(ii) the sum of the DRG payment for the case as computed in ARM 37.86.2907 and the appropriate outlier as computed in ARM 37.86.2916, if any.

(b) A discharging hospital (i.e., the hospital to which the recipient is transferred) reimbursed under ARM 37.86.2907 is paid the full DRG payment plus any appropriate outliers.

(4) Outpatient hospital services other than diagnostic services that are provided within the 24 hours preceding the inpatient hospital admission must be bundled into the inpatient claim.

(5) Diagnostic services (including clinical diagnostic laboratory tests) provided within 72 hours prior to the date of admission are deemed to be inpatient services and must be bundled into the inpatient claim. (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04; AMD, 2005 MAR p. 265, Eff. 2/11/05; AMD, 2006 MAR p. 768, Eff. 3/24/06.)

Rule 37.86.2919 reserved

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37.86.2920 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, HOSPITAL RESIDENTS (1) Payment for hospital residents will be made as follows:

(a) upon obtaining hospital residency status, claims for that recipient may be billed on an interim basis;

(b) payment for the first 180 days of inpatient care will be the DRG payment for the case as computed in ARM 37.86.2907 and any appropriate outlier payment as computed in ARM 37.86.2916; and

(c) payment for all patient care subsequent to 180 days will be reimbursed at a rate computed by multiplying the statewide average cost to charge ratio by the usual and customary billed charges. (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04.)

37.86.2921 HOSPITAL RESIDENCY STATUS (1) A recipient who is unable to be cared for in a setting other than the acute care hospital is eligible for hospital residency status.

(2) To obtain hospital residency status, the recipient must meet the following requirements:

(a) the recipient must utilize a ventilator for a continuous period of not less than eight hours in a 24-hour period or require at least 10 hours of direct nursing care in a 24-hour period; and

(b) the recipient must have been an inpatient in an inpatient hospital for a minimum of six continuous months.

(3) The provider will have the responsibility of determining whether services could be provided in a skilled nursing care facility or by the home and community based waiver program to a Medicaid recipient within the state of Montana.

(4) The provider shall maintain written records of inquiries and responses about the present and future availability of openings in nursing homes and the home and community based waiver program.

(5) A redetermination of nursing home or waiver availability must be made at least every six months. (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-149, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04.)

Rules 37.86.2922 and 37.86.2923 reserved

37.86.2924 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, CERTIFIED REGISTERED NURSE ANESTHETISTS (1) If the Secretary of Health and Human Services has granted the facility authorization for continuation of cost pass-through under section 9320 of the Omnibus Budget Reconciliation Act of 1986, as amended by section 608(c) of the Family Support Act of 1988 (Public Law 100-485), the department shall reimburse inpatient hospital service providers for certified registered nurse anesthetist costs on a reasonable cost basis as provided in ARM 37.86.2801(2). (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04.)

37.86.2925 INPATIENT HOSPITAL REIMBURSEMENT, DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS (1) Routine disproportionate share hospitals (RDSH) shall receive an additional payment amount equal to the product of the hospital's prospective base rate times the adjustment percentage of:

(a) 4% for rural hospitals; or

(b) 5% for urban hospitals.

(2) Subject to federal approval and the availability of sufficient state special revenue, all supplemental disproportionate share hospitals shall receive a supplemental disproportionate share hospital payment. In order to maintain access and quality in the most rural areas in Montana, critical access hospitals and exempt hospitals shall receive an increased portion of the available funding. The supplemental disproportionate share hospital payment shall be calculated using the formula: SDSH=(M/D)*P.

(a) For the purposes of the determining supplemental disproportionate share hospital payment amounts, the following definitions apply:

(i) "SDSH" represents the calculated supplemental disproportionate share hospital amount.

(ii) "M" represents the number of weighted Medicaid paid inpatient days provided by the hospital for which the payment amount is being calculated.

(A) For critical access hospitals and exempt hospitals, weighted Medicaid inpatient days shall equal the number of Medicaid inpatient days provided multiplied by 3.8.

(B) For all other hospitals, weighted Medicaid inpatient days equals the number of Medicaid paid inpatient days provided.

(iii) "D" equals the total number of weighted Medicaid paid inpatient days provided by all supplemental disproportionate share hospitals in Montana.

(iv) "P" equals the unexpended, unencumbered disproportionate share hospital allotment for Montana, as determined by CMS according to section 1923 of the Social Security Act, remaining after routine disproportionate share hospital payments have been calculated according to (1), plus the state financial participation.

(v) The figures used in (2)(a)(ii) and (iii) must be from the department's paid claims data for the hospital's fiscal year that ended in the most recent calendar year that ended at least 12 months prior to the calculation of the HRA payments.

(3) Disproportionate share hospital payments, including routine disproportionate share hospital payments and supplemental disproportionate share hospital payments will be limited to the cap established by the federal Centers for Medicare and Medicaid Services (CMS) for the state of Montana. The adjustment percentages specified in this rule shall be ratably reduced as determined necessary by the department to avoid exceeding the cap.

(4) Eligibility for routine disproportionate share hospital and supplemental disproportionate share hospital payments will be determined based on a provider's year-end reimbursement status. (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04.)

Rules 37.86.2926 and 37.86.2927 reserved

37.86.2928 INPATIENT HOSPITAL REIMBURSEMENT, HOSPITAL REIMBURSEMENT ADJUSTOR (1) All hospitals meeting the eligibility requirements in ARM 37.86.2940 shall receive a hospital reimbursement adjustor (HRA) payment. The payment consists of two separately calculated amounts. In order to maintain access and quality in the most rural areas of Montana, critical access hospitals and exempt hospitals shall receive both components of the HRA. All other hospitals shall receive only Part 1, as defined in (2)(a). Eligibility for an HRA payment will be determined based on a hospital's year-end reimbursement status.

(2) Part 1 of the HRA payment will be based upon Medicaid inpatient utilization, and will be computed as follows: HRA1 = (M ÷ D) x P.

(a) For the purposes of calculating Part 1 of the HRA, the following apply:

(i) "HRA1" represents the calculated Part 1 HRA payment.

(ii) "M" equals the number of Medicaid inpatient days provided by the hospital for which the payment amount is being calculated.

(iii) "D" equals the total number of Medicaid inpatient days provided by all hospitals eligible to receive an HRA payment.

(iv) "P" equals the total amount to be paid via Part 1 of the HRA. "P" consists of a state paid amount plus the applicable federal financial participation, FFP. The portion of "P" that is paid by the state will equal the amount of revenue generated by Montana's hospital utilization fee, less all of the following:

(A) the amount expended as match for supplemental DSH payments as provided in ARM 37.86.2925;

(B) 4% of the total revenue generated by the hospital utilization fee, which will be expended as match for continuity of care adjustor payments, as provided in ARM 37.88.1106; and

(C) 8% of the total revenue generated by the hospital utilization fee, which will be expended as match for Part 2 of the HRA, as provided in (3).

(3) Part 2 of the IRA payment will be based upon total hospital Medicaid charges, and will be computed as follows: HRA2 = (I ÷ D) x P.

(a) For the purposes of calculating Part 2 of the HRA, the following apply:

(i) "HRA2" represents the calculated Part 2 HRA payment.

(ii) "I" equals the total hospital charges from Medicaid paid claims for which Montana Medicaid was the primary payer for the hospital for which the payment is being calculated.

(iii) "D" equals the total hospital charges from Medicaid paid claims for which Montana Medicaid was the primary payer for all hospitals eligible to receive Part 2 of the HRA payment.

(iv) "P" equals the total amount to be paid via Part 2 of the HRA. "P" will be 8% of the total revenue generated by Montana's hospital utilization fee plus applicable federal financial participation.

(b) The numbers used in (2) through (3)(a)(iv) must be from the department's paid claims data from the most recent calendar year that ended at least 12 months prior to the calculation of the HRA payments.

(c) For hospitals that have not been operating for two full calendar years when the HRA payments are calculated, the department may use Medicaid paid claim data from a partial or more recent 12-month period or both in order to make the calculations. (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-149, MCA; NEW, 2004 MAR p. 650, Eff. 2/27/04; AMD, 2006 MAR p. 768, Eff. 3/24/06.)

Rules 37.86.2929 and 37.86.2930 reserved

37.86.2931 ROUTINE AND SUPPLEMENTAL DISPROPORTIONATE SHARE HOSPITAL (1) A hospital is deemed a routine disproportionate share hospital if:

(a) it has a Medicaid inpatient utilization rate of at least one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments in Montana or a low income utilization rate exceeding 20%; and

(b) it has a Medicaid inpatient utilization rate of at least 1%.

(2) Urban hospitals must have at least two obstetricians with staff privileges who have agreed to provide obstetric services to Medicaid patients. Rural hospitals must have at least two physicians with staff privileges to perform nonemergent obstetric procedures who have agreed to provide obstetric services to Medicaid recipients.

(3) This rule does not apply to hospitals which:

(a) serve inpatients who are predominantly individuals under 18 years of age; or

(b) do not offer nonemergent obstetric services as of December 21, 1987.

(4) A hospital is deemed a supplemental disproportionate share hospital if it meets the criteria in (1)(b), (2), and (3). (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-149, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04.)

37.86.2932 MEDICAID UTILIZATION RATE (1) A hospital's Medicaid utilization rate is the hospital's percentage rate computed by dividing the total number of Medicaid inpatient days in the hospital's fiscal year by the total number of the hospital's inpatient days in that same period.

(2) The period used to determine whether a hospital is deemed a routine disproportionate share hospital will be the most recent calendar year for which final cost reports are available for all hospital providers.

(3) The period used to determine whether a hospital is deemed a supplemental disproportionate share hospital will be the same period used to calculate the amounts of the supplemental DSH payments, as provided in ARM 37.86.2925.

(a) An inpatient day includes each day in which an individual, including a newborn, is an inpatient in the hospital, whether or not the individual is in a specialized ward or whether or not the individual remains in the hospital for lack of suitable placement elsewhere. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04.)

Rules 37.86.2933 and 37.86.2934 reserved

37.86.2935 CALCULATING LOW INCOME UTILIZATION RATE, FOR ROUTINE DISPROPORTIONATE SHARE HOSPITALS (1) The low income utilization rate is used to determine whether a hospital is deemed a routine disproportionate share hospital. The percentage rate is computed as follows:

(a) LIUR=((A + B)/C) + (D/E) where:

(i) "LIUR" is the low income utilization rate;

(ii) "A" is the total revenue paid to the hospital to determine patient services under the Medicaid state plan regardless of whether the services were furnished on a fee-for-service basis or through a managed care program in the hospital's fiscal year;

(iii) "B" is the cash subsidies received directly from state and local governments for patient services in the hospital's fiscal year;

(iv) "C" is the total revenues of the hospital for patient services, including the amount of such cash subsidies in the hospital's fiscal year;

(v) "D" is the total hospital charges for inpatient hospital services attributable to charity care in the hospital's fiscal year, less any amount received for payment of these charges attributable to inpatient services. This amount shall not include contractual allowances and discounts (other than for indigent patients not eligible for public assistance); and

(vi) "E" is the hospital's total charges for inpatient hospital services in the hospital's fiscal year.

(b) The above amounts used in the formula must be from the hospital's most recent fiscal year for which initial cost reports are available for all hospital providers. (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-149, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04.)

Rules 37.86.2936 through 37.86.2939 reserved

37.86.2940 HOSPITAL REIMBURSEMENT ADJUSTOR (HRA), DATA SOURCES (1) A hospital reimbursement adjustor (HRA) payment will be made to an eligible Montana hospital licensed pursuant to Title 50, chapter 5, MCA, as either a hospital or a critical access hospital, that provides inpatient hospital services.

(2) Data sources for the department to determine which hospitals meet the criteria to receive an HRA payment, and the amount of the payment, may include, but are not limited to:

(a) the Montana Hospital Association (MHA) database;

(b) the Medicaid paid claims database;

(c) filed or settled cost reports; and

(d) reports from the Licensing Bureau of the Quality Assurance Division.

(3) Eligibility evaluations, payment amount calculations, and payments will be made annually.

(4) The Montana State Hospital is not eligible for HRA. (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-149, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04.)

Rules 37.86.2941 and 37.86.2942 reserved

37.86.2943 BORDER HOSPITAL REIMBURSEMENT (1) Inpatient hospital services provided in border hospitals will be reimbursed under the DRG prospective payment system described in ARM 37.86.2907, 37.86.2912, 37.86.2914, 37.86.2916, 37.86.2918, 37.86.2920, and 37.86.2924.

(2) In addition to the prospective rate, border hospitals will be reimbursed for cost outliers as set forth in ARM 37.86.2916, and for capital costs as set forth in ARM 37.86.2912, but shall not be reimbursed in addition to the DRG payment for medical education costs, neonatal intensive care stop-loss reimbursement, or certified registered nurse anesthetist costs. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04.)

Rules 37.86.2944 through 37.86.2946 reserved

37.86.2947 OUT-OF-STATE HOSPITAL REIMBURSEMENT

(1) Inpatient hospital services provided in hospitals located more than 100 miles outside the borders of the state of Montana will be reimbursed 50% of usual and customary billed charges for medically necessary services.

(2) Medicaid reimbursement for inpatient services shall not be made to hospitals located more than 100 miles outside the borders of Montana unless the provider has obtained authorization from the department or its designated review organization prior to providing services. All inpatient services provided in an emergent situation must be authorized within 48 hours. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04.)

Subchapter 30

Outpatient Hospital Services

37.86.3001 OUTPATIENT HOSPITAL SERVICES, DEFINITIONS

(1) "Ambulatory payment classification (APC)" means Medicare's ambulatory payment classification assignment groups of HCPCS codes.

(2) "Conversion factor" means an adjustment equal to Medicare's highest urban rate for Montana as published at 67 Federal Register (FR) 43616 (June 28, 2002).

(3) "Diagnostic service" means an examination or procedure performed on an outpatient or on materials derived from an outpatient to obtain information to aid in the assessment or identification of a medical condition.

(4) "Full-day partial hospitalization program" means a partial hospitalization program providing services at least six hours per day, five days per week.

(5) "Half-day partial hospitalization program" means a partial hospitalization program providing services for at least four but less than six hours per day, at least four days per week.

(6) "Healthcare common procedures coding system (HCPCS)" means the national uniform coding method maintained by the Centers for Medicare and Medicaid Services (CMS) that incorporates the American Medical Association (AMA) Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels, I, II, and III.

(7) "ICD-9-CM" means the International Classification of Diseases, Ninth Revision based on the official version of the United Nations World Health Organization's Ninth Revision.

(8) "Imaging service" means diagnostic and therapeutic radiology, nuclear medicine, CT scan procedures, magnetic resonance imaging services, ultra-sound, and other imaging procedures.

(9) "Outpatient" means a person who:

(a) has not been admitted by a hospital as an inpatient;

(b) is expected by the hospital to receive services in the hospital for less than 24 hours;

(c) is registered on the hospital records as an outpatient; and

(d) receives outpatient hospital services from the hospital, other than supplies or drugs alone, for nonemergency medical conditions.

(10) "Outpatient hospital services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner as permitted by federal law, by an institution that:

(a) is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and

(b) except as otherwise permitted by federal law, meets the requirements for participation in Medicare as a hospital.

(11) "Outpatient prospective payment system" (OPPS) means Medicare's outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.

(12) "Partial hospitalization services" means an active treatment program that offers therapeutically intensive, coordinated, structured clinical services provided only to individuals who are determined to have a serious emotional disturbance or severe disabling mental illness. Partial hospitalization services are time-limited and provided within either an acute level program or a sub-acute level program. Partial hospitalization services include day, evening, night, and weekend treatment programs that employ an integrated, comprehensive, and complementary schedule of recognized treatment or therapeutic activities.

(a) Acute level partial hospitalization is provided by programs which:

(i) are operated by a hospital as described in 50-5-101, MCA and are colocated with that hospital such that in an emergency a patient of the acute partial hospitalization program can be transported to the hospital's inpatient psychiatric unit within 15 minutes;

(ii) serve primarily individuals being discharged from inpatient psychiatric treatment or inpatient psychiatric residential treatment; and

(iii) provide psychotherapy services consisting of at least individual, family, and group sessions at a frequency designed to stabilize patients sufficiently to allow discharge to a less intensive level of care at the earliest appropriate opportunity, on average, after 15 or fewer treatment days.

(b) Acute level partial hospitalization is reimbursed according to ARM 37.86.3022.

(c) Sub-acute level partial (SAP) hospitalization is provided by programs which:

(i) operate under the license of a general hospital with a distinct psychiatric unit or an inpatient psychiatric hospital for individuals under 21;

(ii) operate in a self-contained facility and offer integrated mental health services appropriate to the individual's needs as identified in an individualized treatment plan;

(iii) provide psychotherapy services consisting of at least three group sessions per week and five individual and/or family sessions per month;

(iv) encourage and support parent and family involvement;

(v) provide services in a supervised environment by a well-integrated, multi-disciplinary team of professionals which includes but is not limited to program therapists, behavioral specialists, teachers, and ancillary staff;

(A) a program therapist must be a licensed mental health professional who is site based;

(B) a program therapist must have an active caseload that does not exceed 10 program clients;

(C) a behavioral specialist must be site based and have a bachelor's degree in a behavioral science field or commensurate experience working with children with serious emotional disturbance. There must be one behavioral specialist for each five youth in the SAP program; and

(D) all staff responsible for implementing the treatment plan must have a minimum of 24 hours orientation training and 12 additional hours of continuing education each year relating to serious emotional disturbance in children and its treatment. Training must include specific instruction on recognizing the effects of medication.

(vi) provide education services through one of the following:

(A) full collaboration with a school district;

(B) certified education staff within the program; or

(C) interagency agreements with education agencies.

(vii) provide crisis intervention and management, including response outside of the program setting;

(viii) provide psychiatric evaluation, consultation, and medication management on a regular basis. Psychiatric consultation to the program treatment staff is provided at least twice each month and includes at least one face-to-face evaluation with each youth each month;

(ix) serve children or youth with a serious emotional disturbance being discharged from inpatient psychiatric treatment or residential treatment or who would be admitted to such treatment in the absence of partial hospitalization; and

(x) are designed to stabilize patients sufficiently to allow discharge to a less intensive level of care, on average, after 60 or fewer treatment days.

(d) Sub-acute level partial hospitalization is reimbursed at the rate specified in the department's Medicaid Mental Health Fee Schedule.

(13) "Qualified rate adjustment" (QRA) payment means an additional payment to a county owned, operated or partially county funded rural hospital in Montana as provided in ARM 37.86.3005, when the hospital's most recently reported costs are greater than the reimbursement received from Montana Medicaid for outpatient care. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA; NEW, Eff. 11/4/74; AMD, 1983 MAR p. 756, Eff. 7/1/83; AMD, 1994 MAR p. 1732, Eff. 7/1/94; AMD, 1995 MAR p. 1162, Eff. 7/1/95; AMD, 1996 MAR p. 1539, Eff. 7/1/96; AMD, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 27, Eff. 3/1/01; EMERG, AMD, 2001 MAR p. 989, Eff. 6/8/01; AMD, 2002 MAR p. 1991, Eff. 8/1/02; AMD, 2003 MAR p. 1652, Eff. 8/1/03; AMD, 2005 MAR p. 265, Eff. 2/11/05; AMD, 2006 MAR p. 768, Eff. 3/24/06.)

37.86.3002 OUTPATIENT HOSPITAL SERVICES, SCOPE AND REQUIREMENTS (1) The requirements of ARM 37.86.2801, 37.86.2803, 37.86.3001, 37.86.3005, and this rule are in addition to those contained in rule provisions generally applicable to Medicaid providers.

(2) Outpatient hospital services do not include:

(a) services excluded from coverage by the Medicaid program under ARM 37.85.207;

(b) exercise programs and programs primarily educational in nature, including but not limited to:

(i) cardiac rehabilitation exercise programs;

(ii) nutritional programs;

(iii) independent exercise programs, such as pool therapy, swim programs or health club memberships;

(iv) pulmonary therapy; or

(c) outpatient physical therapy, occupational therapy, and speech therapy services that are primarily maintenance therapy as defined in ARM 37.86.601.

(3) Outpatient hospital services are services that would also be covered by Medicaid if provided in a nonhospital setting and are limited to the following diagnostic and therapeutic services furnished by hospitals to outpatients:

(a) diagnostic services, including:

(i) the services of nurses, psychologists, and technicians;

(ii) drugs and biologicals;

(iii) laboratory and imaging services;

(iv) psychological tests;

(v) supplies and equipment; and

(vi) other tests to determine the nature and severity of a medical condition;

(b) therapeutic services and supplies, including:

(i) emergency room services;

(ii) clinic services; and

(iii) the use of hospital facilities incident to provision of physician services to the patient where the services and supplies are furnished in the hospital on a physician's order by hospital personnel under the supervision of hospital medical staff;

(c) chemical dependency treatment services;

(d) services provided outside the hospital, as follows:

(i) diagnostic services provided by hospital personnel outside the hospital premises with or without direct personal supervision of a physician;

(ii) therapeutic services that are incident to physician services and provided under the direct personal supervision of a physician. Outpatient physical therapy, occupational therapy, and speech therapy are not subject to the direct physician supervision requirement. Therapy services are limited as in ARM 37.86.606; and

(e) diabetic education services provided by a hospital whose diabetic education protocol has been approved by the Medicare Part A Program, P.O. Box 5017, Great Falls, MT 59403. Coverage of diabetic education services is limited to those services meeting the requirements of the Health Care Financing Administration Hospital Manual, CMS Publication 10, Coverage Issues, Appendix Section 80-2, as amended through March 27, 2003. A copy of this section is adopted and incorporated by reference and is available through the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(4) Outpatient hospital services provided outside the borders of the United States will not be covered or reimbursed by the Montana Medicaid program. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA; NEW, 1983 MAR p. 756, Eff. 7/1/83; AMD, 1993 MAR p. 2819, Eff. 11/1/93; AMD, 1994 MAR p. 1732, Eff. 7/1/94; AMD, 1995 MAR p. 1162, Eff. 7/1/95; AMD, 1996 MAR p. 1682, Eff. 6/21/96; AMD, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1997 MAR p. 1209, Eff. 7/8/97; AMD, 1997 MAR p. 1269, Eff. 7/22/97; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 1119, Eff. 6/22/01; AMD, 2003 MAR p. 1652, Eff. 8/1/03; AMD, 2004 MAR p. 482, Eff. 2/27/04.)

Rules 37.86.3003 and 37.86.3004 reserved

37.86.3005 OUTPATIENT HOSPITAL SERVICES, REIMBURSEMENT AND QUALIFIED RATE ADJUSTMENT PAYMENT (1) The department will reimburse for outpatient hospital services compensable under the Montana Medicaid program as provided in this rule.

(2) Outpatient hospital services that are not provided by exempt hospitals or critical access hospitals as defined in ARM 37.86.2901 will be reimbursed under ARM 37.86.3007, 37.86.3009, 37.86.3016, 37.86.3018, 37.86.3020, and 37.86.3025 for medically necessary services.

(3) For critical access hospitals and exempt hospitals, interim reimbursement for outpatient hospital services is based on hospital specific Medicaid outpatient cost to charge ratio, not to exceed 100%. Critical access hospitals and exempt hospitals will be reimbursed their actual allowable costs determined according to ARM 37.86.2803. If a provider fails or refuses to submit the financial information, including the Medicare cost report, necessary to determine the cost to charge ratio, the provider's interim rate will be 50% of its usual and customary charges (billed charges).

(4) Subject to the availability of sufficient county and federal funding, the department will pay in addition to the established Medicaid rates provided in this rule a qualified rate adjustment payment to an eligible rural hospital in Montana as provided in ARM 37.86.2810. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA; NEW, 1987 MAR p. 1658, Eff. 10/1/87; AMD, 1991 MAR p. 1027, Eff. 7/1/91; AMD, 1993 MAR p. 1520, Eff. 7/16/93; AMD, 1994 MAR p. 1732, Eff. 7/1/94; AMD, 1995 MAR p. 1162, Eff. 7/1/95; AMD, 1995 MAR p. 1961, Eff. 10/1/95; AMD, 1996 MAR p. 1539, Eff. 7/1/96; AMD, 1996 MAR p. 3218, Eff. 12/20/96; AMD, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1997 MAR p. 1209, Eff. 7/8/97; AMD, 1998 MAR p. 2168, Eff. 8/14/98; AMD, 1999 MAR p. 1806, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 564, Eff. 1/12/01; EMERG, AMD, 2001 MAR p. 1119, Eff. 6/22/01; AMD, 2002 MAR p. 797, Eff. 3/15/02; AMD, 2002 MAR p. 1991, Eff. 8/1/02; AMD, 2003 MAR p. 1652, Eff. 8/1/03; AMD, 2004 MAR p. 482, Eff. 2/27/04.)

37.86.3006 MENTAL HEALTH OUTPATIENT PARTIAL HOSPITAL SERVICES, PROSPECTIVE PAYMENT METHODOLOGY (1) Medicaid reimbursement is not available for outpatient partial hospitalization services unless the provider submits to the department or its designee in accordance with these rules a complete and accurate Certificate of Need, certifying that:

(a) the recipient is experiencing psychiatric symptoms of sufficient severity to create severe impairments in educational, social, vocational, and/or interpersonal functioning;

(b) the recipient cannot be safely and appropriately treated or contained in a less restrictive level of care;

(c) proper treatment of the beneficiary's psychiatric condition requires acute treatment services on an outpatient basis under the direction of a physician;

(d) the services can reasonably be expected to improve the recipient's condition or prevent further regression; and

(e) the recipient has exhausted or cannot be safely and effectively treated by less restrictive alternative services, including day treatment services or a combination of day treatment and other services.

(2) For recipients determined Medicaid eligible by the department as of the time of admission to the partial hospitalization program, the Certificate of Need required under (1) must be:

(a) completed, signed and dated prior to, but no more than 30 days before, admission; and

(b) made by a team of health care professionals that has competence in diagnosis and treatment of mental illness and that has knowledge of the recipient's situation, including the recipient's psychiatric condition. No more than one member of the team of health care professionals may be professionally or financially associated with a partial hospitalization program. The team must include:

(i) a physician that has competence in diagnosis and treatment of mental illness, preferably in psychiatry;

(ii) a licensed mental health professional; and

(iii) an intensive case manager employed by a mental health center or other individual knowledgeable about local mental health services as designated by the department.

(3) For recipients who are being transferred from a hospital's acute inpatient program to the same facility's partial hospitalization program, the certificate of need required under (1) may be completed by a facility based team of health care professionals:

(a) that has competence in diagnosis and treatment of mental illness and that has knowledge of the recipient's psychiatric condition;

(b) that includes a physician that has competence in diagnosis and treatment of mental illness, preferably in psychiatry, and a licensed mental health professional; and

(c) the Certificate of Need must also be signed by an intensive case manager employed by a mental health center or other individual knowledgeable about local mental health services as designated by the department.

(4) For recipients determined Medicaid eligible by the department after admission to or discharge from the facility, the Certificate of Need required under (1) is waived. A retrospective review to determine the medical necessity of the admission to the program and the treatment provided will be completed by the department or its designee at the request of the department, a provider, the individual, or the individual's parent or guardian. Request for retrospective review must be:

(a) received within 14 days after the eligibility determination for recipients determined eligible following admission, but before discharge from the partial hospitalization program; or

(b) received within 90 days after the eligibility determination for recipients determined eligible after discharge from the partial hospitalization program.

(5) All Certificates of Need required under (1) must actually and personally be signed by each team member, except that signature stamps may be used if the team member actually and personally initials the document over the signature stamp.

(6) Prior authorization is not a guarantee of payment as Medicaid rules and regulations, client eligibility, or additional medical information on retrospective review may cause the department to refuse payment. (History: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04.)

37.86.3007 OUTPATIENT HOSPITAL SERVICES, PROSPECTIVE PAYMENT METHODOLOGY, CLINICAL DIAGNOSTIC LABORATORY SERVICES

(1) Clinical diagnostic laboratory services, including automated multichannel test panels (commonly referred to as "ATPs") and lab panels, will be reimbursed on a fee basis as follows with the exception of hospitals reimbursed under ARM 37.86.3005 and specific lab codes which are paid under ARM 37.86.3020:

(a) The fee for a clinical diagnostic laboratory service is the lesser of the provider's usual and customary charge (billed charges) or the applicable percentage of the Medicare fee schedule as follows:

(i) 60% of the prevailing Medicare fee schedule where a hospital laboratory acts as an independent laboratory, i.e., performs tests for persons who are nonhospital patients;

(ii) 62% of the prevailing Medicare fee schedule for a hospital designated as a sole community hospital as defined in ARM 37.86.2901; or

(iii) 60% of the prevailing Medicare fee schedule for a hospital that is not designated as a sole community hospital as defined in ARM 37.86.2901.

(b) For clinical diagnostic laboratory services:

(i) where no Medicare fee has been assigned, the fee is 62% of usual and customary charges (billed charges) for a hospital designated as a sole community hospital as defined in ARM 37.86.2901 or 60% of usual and customary charges (billed charges) for a hospital that is not designated as a sole community hospital as defined in ARM 37.86.2901; or

(ii) if a Medicaid fee has been assigned, the fee is the amount set in ARM 37.85.212(9).

(c) For purposes of this rule, clinical diagnostic laboratory services include the laboratory tests listed in codes defined in the HCPCS. Certain tests are exempt from the fee schedule. These tests are listed in the CMS Publication 45 (Pub. 45) last modified August 28, 2002, State Medicaid Manual, Payment For Services, Section 6300. These exempt clinical diagnostic laboratory services will be reimbursed under the retrospective payment methodology specified in ARM 37.86.3005(2).

(d) Specimen collection will be reimbursed separately for drawing a blood sample through venipuncture or for collecting a urine sample by catheterization. Specimen collection will be reimbursed as specified in the department's outpatient fee schedule as adopted in ARM 37.86.3025, whether or not the specimens are referred to physicians or other laboratories for testing. No more than one collection fee may be allowed for each patient visit, regardless of the number of specimens drawn. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2002 MAR p. 1991, Eff. 8/1/02; AMD, 2003 MAR p. 1652, Eff. 8/1/03; AMD, 2005 MAR p. 265, Eff. 2/11/05.)

Rule 37.86.3008 reserved

37.86.3009 OUTPATIENT HOSPITAL SERVICES, PAYMENT METHODOLOGY, EMERGENCY VISIT SERVICES (1) Emergency visits are emergency room services for which the ICD-9-CM presenting diagnosis code (admitting diagnosis code) or the diagnosis code (primary or secondary diagnosis code) chiefly responsible for the services provided is a diagnosis designated by the department as an emergency diagnosis in the Medicaid emergency diagnosis list or the claim includes a CPT code designated by the department as an emergency procedure code. PASSPORT provider authorization is not required for these visits. For purposes of this rule, the department adopts and incorporates by reference the Emergency Diagnosis and Procedure Code List effective January 1, 2005. The Emergency Diagnosis and Procedure Code List is available upon request from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) For emergency visits that are not provided by exempt hospitals or critical access hospitals as defined in ARM 37.86.2901 and meet (1), reimbursement will be based on the ambulatory payment classifications APC methodology in ARM 37.86.3020, except for emergency room visits on evenings and weekends for Medicaid clients from birth to 24 months of age.

(a) Evenings are defined as from 6 p.m. on Monday, Tuesday, Wednesday, and Thursday until 8 a.m. of the following day.

(b) Weekends are defined as from 6 p.m. Friday until 8 a.m. on Monday.

(3) For emergency visits not meeting (1), reimbursement will be a prospective fee for evaluation and stabilization as specified in the department's outpatient fee schedule plus ancillary reimbursement for laboratory, imaging and other diagnostic services not included in the APR reimbursement. The evaluation and stabilization fee is considered payment in full.

(4) An evaluation and stabilization fee is an all inclusive bundled payment per visit which covers all outpatient services provided to the patient, including but not limited to nursing, pharmacy, supplies, equipment, and other outpatient hospital services.

(5) Physician services are separately billable according to the applicable rules governing billing for physician services.

(6) For emergency visits which the medical professional rendering the screening and evaluation determine are emergent but not on the department's emergency list, a hospital may send the claim and emergency room documentation for review to the department for payment of a fee other than the evaluation and stabilization fee. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2001 MAR p. 1119, Eff. 6/22/01; EMERG, AMD, 2002 MAR p. 2665, Eff. 9/27/02; AMD, 2003 MAR p. 1652, Eff. 8/1/03; AMD, 2004 MAR p. 482, Eff. 2/27/04; AMD, 2005 MAR p. 265, Eff. 2/11/05.)

Rule 37.86.3010 reserved

37.86.3011 OUTPATIENT HOSPITAL SERVICES, PROSPECTIVE PAYMENT METHODOLOGY, NONEMERGENT EMERGENCY ROOM SERVICES (REPEALED) (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2001 MAR p. 1119, Eff. 6/22/01; EMERG, AMD, 2002 MAR p. 2665, Eff. 9/27/02; REP, 2003 MAR p. 1652, Eff. 8/1/03.)

Rules 37.86.3012 and 37.86.3013 reserved

37.86.3014 OUTPATIENT HOSPITAL SERVICES, PROSPECTIVE PAYMENT METHODOLOGY, DIALYSIS SERVICES (1) Dialysis visits will be reimbursed at the provider's Medicare composite rate for dialysis services determined by Medicare under 42 CFR subpart H. The facility's composite rate is a comprehensive prospective payment for all modes of facility and home dialysis and constitutes payment for the complete dialysis treatment, except for a physician's professional services, separately billable laboratory services and separately billable drugs. The provider must furnish all of the necessary dialysis services, equipment and supplies. Reimbursement for dialysis services and supplies is further defined in the Medicare Provider Reimbursement Manual, CMS Publication 15 last updated August 27, 2002 (Pub. 15). For purposes of specifying the services covered by the composite rate and the services that are separately billable, the department adopts and incorporates by reference Pub. 15. A copy of Pub. 15 may be obtained through the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2003 MAR p. 1652, Eff. 8/1/03.)

Rule 37.86.3015 reserved

37.86.3016 OUTPATIENT HOSPITAL SERVICES, PROSPECTIVE PAYMENT METHODOLOGY, IMAGING SERVICES (1) Imaging services will be reimbursed as in ARM 37.86.3020 with the exception of hospitals reimbursed under ARM 37.86.3005(3) and except as follows:

(a) For each imaging service or procedure, the fee will be the lesser of the provider's usual and customary charges (billed charges) or 100% of the Medicare APC rate. The imaging services reimbursed under this subsection are the individual imaging service codes defined in the HCPCS.

(b) For imaging services where no APC rate or Medicare fee has been assigned, the fee is 62% of usual and customary charges (billed charges) for a hospital designated as a sole community hospital as defined in ARM 37.86.2901 or 60% of usual and customary charges (billed charges) for a hospital that is not designated as a sole community hospital as defined in ARM 37.86.2901.

(c) For imaging services where no APC rate has been assigned, outpatient hospital-specific percent of charges will be paid. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2001 MAR p. 1119, Eff. 6/22/01; AMD, 2002 MAR p. 1991, Eff. 8/1/02; AMD, 2003 MAR p. 1652, Eff. 8/1/03.)

Rule 37.86.3017 reserved

37.86.3018 OUTPATIENT HOSPITAL SERVICES, PROSPECTIVE PAYMENT METHODOLOGY, OTHER DIAGNOSTIC SERVICES (1) Other diagnostic services will be reimbursed as follows with the exception of hospitals reimbursed under ARM 37.86.3005(3):

(a) the lesser of the provider's usual and customary charges (billed charges) or 100% of the Medicare APC rate. The individual diagnostic services reimbursed under this subsection are those defined in the HCPCS;

(b) other diagnostic services without a Medicare APC rate and for which no Medicare APC rate has been assigned will be reimbursed under the retrospective cost basis as specified in ARM 37.86.3005(3); or

(c) for other diagnostic services without an APC rate, but for which a Medicaid fee has been assigned, the fee will be set in accordance with the RBRVS methodology in ARM 37.85.212. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2001 MAR p. 1119, Eff. 6/22/01; AMD, 2002 MAR p. 1991, Eff. 8/1/02; AMD, 2003 MAR p. 1652, Eff. 8/1/03.)

Rule 37.86.3019 reserved

37.86.3020 OUTPATIENT HOSPITAL SERVICES, OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) METHODOLOGY, AMBULATORY PAYMENT CLASSIFICATION (1) Outpatient hospital services that are not provided by exempt hospitals or critical access hospitals as defined in ARM 37.86.2901(4) and (8) will be reimbursed on a rate-per-service basis using the Outpatient Prospective Payment System (OPPS) schedules. Under this system, Medicaid payment for hospital outpatient services included in the OPPS is made at a predetermined, specific rate. These outpatient services are classified according to a list of APCs published annually in the Code of Federal Regulations (CFR). The rates for OPPS are determined as follows:

(a) The department uses a conversion factor for each APC group based on Montana's highest Medicare urban rate, as published annually in the CFR. The APC based fee equals the Medicare specific relative weight for the APC times the conversion factor that is the same for all APCs with the exceptions of services in ARM 37.86.3025. APCs are based on classification assignment of HCPCS codes.

(b) At the claim level, payment will be the lower of the provider's charge and the payment as calculated using OPPS. There will be no charge cap at the line level.

(c) APCs are an all inclusive bundled payment per visit which covers all outpatient services provided to the patient, including but not limited to nursing, pharmacy, laboratory, imaging services, other diagnostic services, supplies and equipment, and other outpatient services. For purposes of OPPS, a visit includes all outpatient hospital services related or incident to the outpatient visit that are provided the day before or the day of the outpatient visit.

(d) If two or more surgical procedures are performed at the same hospital on the same patient on the same day, payment for the most expensive procedure will be made at 100% of the APC for that service and payment for all other procedures will be made at 50% of the APC for those services.

(e) If the OPPS does not assign a fee or APC for a particular procedure code, but for which a Medicaid fee has been assigned, the fee will be set in accordance with the resource based relative value scale (RBRVS) methodology found at ARM 37.85.212. If there is not a Medicaid fee, the service will be reimbursed at hospital specific outpatient cost to charge ratio.

(i) If a provider fails or refuses to submit the financial information, including the Medicare cost report, necessary to determine the cost to charge ratio, the provider's reimbursement will be 50% of its usual and customary charges (billed charges).

(f) The department will make separate payment for observation care procedure codes only if the patient has a primary diagnosis code of asthma, chest pain, congestive heart failure, or obstetric complications. If an observation service does not meet Medicare's criteria for these services, payment for observation care will be considered bundled into the APC for other services.

(i) The diagnosis used to define a potential obstetric qualification will be taken from diagnosis related groups 382 (false labor) and 383 (other antepartum diagnosis with medical complications).

(g) The department follows Medicare guidelines for procedures defined as "inpatient only". When these procedures are performed in the outpatient hospital setting, the claim will be denied.

(h) Procedures started on patients but discontinued before completion will be reimbursed at 50% of the APC for those services.

(2) The department adopts and incorporates by reference the OPPS Schedules published by the Centers for Medicare and Medicaid Services (CMS) in 69 Federal Register 211, November 2, 2004, effective January 1, 2005. A copy may be obtained through the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2001 MAR p. 1119, Eff. 6/22/01; EMERG, AMD, 2002 MAR p. 2665, Eff. 9/27/02; AMD, 2003 MAR p. 1652, Eff. 8/1/03; AMD, 2005 MAR p. 265, Eff. 2/11/05.)

Rule 37.86.3021 reserved

37.86.3022 OUTPATIENT HOSPITAL SERVICES, PARTIAL HOSPITALIZATION SERVICES (1) Partial hospitalization services will be reimbursed on a prospective per diem rate which shall be the lesser of the amount specified in the department's Medicaid Mental Health Fee Schedule or the provider's usual and customary charges (billed charges). The per diem rates specified in the department's Medicaid Mental Health Fee Schedule are bundled prospective per diem rates for full-day programs and half-day programs, as defined in ARM 37.86.3001. The bundled prospective per diem rate includes all outpatient psychiatric and psychological treatments and services, laboratory and imaging services, drugs, biologicals, supplies, equipment, therapies, nurses, social workers, psychologists, licensed professional counselors, and other outpatient services, that are part of or incident to the partial hospitalization program, except as provided in the department's Medicaid Mental Health Fee Schedule.

(2) The professional component of physician services, including psychiatrist services, is separately billable according to the applicable department rules governing billing for physician services. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2004 MAR p. 482, Eff. 2/27/04; AMD, 2006 MAR p. 768, Eff. 3/24/06.)

Rules 37.86.3023 and 37.86.3024 reserved

37.86.3025 OUTPATIENT HOSPITAL SERVICES, REIMBURSEMENT FOR SERVICES NOT PAID UNDER THE AMBULATORY PAYMENT CLASSIFICATION SYSTEM (1) Therapy services will be paid 90% of the reimbursement provided in accordance with the RBRVS methodologies in ARM 37.85.212. Therapy services include physical therapy, occupational therapy, and speech-language pathology.

(2) Screening mammography will be paid the same reimbursement provided in accordance with the RBRVS methodologies in ARM 37.85.212 for HCPCS 76092-TC.

(3) Dental services not grouping to an ambulatory payment classification (APC) will be reimbursed as specified in the department's outpatient fee schedule.

(4) Immunizations not grouping to an APC will be paid the same reimbursement provided in accordance with the RBRVS methodologies in ARM 37.85.212.

(a) If the recipient is under 19 years old and vaccine is available to providers for free under the vaccines for children program, then the payment to the hospital is zero.

(b) Immunization administration is considered an incidental service and will be bundled with other APCs on the claim and paid at zero.

(5) Professional services, except as in (6) and (7), must bill separately on a professional billing form according to applicable rules governing billing for professional services.

(6) For services provided on or after August 1, 2003, hospitals receiving a provider based status from CMS must send a copy of the CMS letter granting provider based status to the department's hospital program officer at Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951 and must receive department approval prior to billing as a provider based clinic.

(a) Physicians, mid-levels, and other professionals billing for services on a professional billing form for services provided in a provider based clinic must show hospital outpatient as the place of service on the claim and will receive payment as in ARM 37.86.105(2).

(b) Physicians, mid-levels, and other professionals providing services that have both a professional and technical component in a provider based clinic may bill only for the professional component of the service. The technical component shall be billed under the hospital's provider number using the appropriate coding and modifiers.

(c) Hospitals granted a provider based status by the department may not restrict access to Medicaid clients.

(7) Interim payment for certified registered nurse anesthetists (CRNAs) will be reimbursed at hospital specific outpatient cost to charge ratio and settled as a pass through in the cost settlement, as provided in ARM 37.86.2924.

(8) The department adopts and incorporates by reference the Outpatient Hospital Fee Schedule dated January 1, 2005. A copy may be obtained through the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2003 MAR p. 1652, Eff. 8/1/03; AMD, 2004 MAR p. 482, Eff. 2/27/04; AMD, 2005 MAR p. 265, Eff. 2/11/05.)

Subchapter 31 reserved

Subchapter 32

Nonhospital Laboratory and Radiology
(X-Ray) Services

37.86.3201 NONHOSPITAL LABORATORY AND RADIOLOGY (X-RAY) SERVICES, REQUIREMENTS (1) "Nonhospital laboratory and radiology (x-ray) services" are professional and technical laboratory and radiology services which are ordered and provided by a physician, dentist or other practitioner licensed within the scope of his practice as defined by state law.

(2) Nonhospital laboratory and radiology (x-ray) services may be provided in an office or similar facility other than a hospital outpatient department or clinic.

(3) Providers must meet the following requirements:

(a) Providers of laboratory services must be:

(i) medicare certified; and

(ii) meet licensing requirements of the state in which they are located.

(b) Providers of radiology services must:

(i) be supervised by a physician who is licensed to practice medicine within the state in which the services are provided; and

(ii) meet state facility licensing requirements, if applicable. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-113 and 53-6-141, MCA; NEW, 1988 MAR p. 2228, Eff. 10/14/88; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1664, Eff. 6/30/00.)

Rules 02 through 04 reserved

37.86.3205 NONHOSPITAL LABORATORY AND RADIOLOGY (X-RAY) SERVICES, REIMBURSEMENT (1) These reimbursement requirements are in addition to those contained in ARM 37.85.212 and 37.86.105.

(2) Independent laboratory providers must meet the following requirements to receive medicaid reimbursement:

(a) the independent laboratory provider must be certified by medicare;

(b) the independent laboratory provider must meet any state licensing requirements for laboratory facilities; and

(c) the independent laboratory service must have been ordered by a physician, dentist or other practitioner licensed to practice in Montana.

(i) Medicaid does not reimburse services ordered by chiropractors.

(3) Independent radiology (x-ray) services must meet the following requirements to receive medicaid reimbursement:

(a) the independent radiology provider must meet any state licensing requirements for radiology facilities;

(b) the independent radiology service must be ordered by a physician, dentist or other practitioner licensed within the scope of his practice as defined by state law;

(c) technical components of diagnostic and therapeutic radiology services must be performed by an appropriately licensed provider within the scope of his practice as defined by state law and under the supervision of a physician; and

(d) the physician with supervisory responsibilities for the radiology services must meet state licensing requirements; and

(e) technical components of the radiology (x-ray) service must be billed by and reimbursed to the supervising physician. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-113 and 53-6-141, MCA; NEW, 1988 MAR p. 2228, Eff. 10/14/88; AMD, 1997 MAR p. 1269, Eff. 7/22/97; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1664, Eff. 6/30/00.)

Subchapter 33

Case Management Services - General

37.86.3301 CASE MANAGEMENT SERVICES, GENERAL DEFINITIONS

(1) "Case management" means the process of planning and coordinating care and services to meet individual needs of a client and to assist the client in obtaining necessary medical, social, nutritional, educational and other services. Case management includes assessment, case plan development, monitoring and service coordination. Case management provides coordination among agencies and providers in the planning and delivery of services.

(2) "Caregiver" means a parent, family member, foster parent, or guardian with legal responsibility for the well-being of the client.

(3) "Case management provider" or "provider" means an entity that as provided for in this subchapter may provide case management services to clients.

(4) "Case manager" means a person or a team of persons assigned by a case management provider to do case management for the client.

(5) "Client" means a person who is eligible for and is receiving case management services.

(6) "Presumptive eligibility" means the process of determining eligibility for pregnant women to receive ambulatory prenatal care services under the medicaid presumptive eligibility program as provided at ARM 37.82.701.

(7) "Department" or "DPHHS" means the department of public health and human services. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1991 MAR p. 1295, Eff. 7/26/91; AMD, 1997 MAR p. 496, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481.)

Rules 02 through 04 reserved

37.86.3305 CASE MANAGEMENT SERVICES, GENERAL PROVISIONS

(1) Case management services assure healthy outcomes by assisting recipients to access needed services and by coordinating between all agencies and providers responsible for service delivery. A case management plan sets goals for meeting a client's needs and where appropriate the needs of the client's caregivers and identifies the means for implementing those goals with emphasis on the self-sufficiency of the client and caregivers in obtaining services.

(2) Case management services are available to persons who are determined by the department or its designees in accordance with this subchapter to be within the covered groups set forth in ARM 37.86.3306.

(3) Receipt of case management services does not restrict a client's right to receive other Montana medicaid services from any certified medicaid provider.

(4) Case management services cannot duplicate any other medicaid service or other services available to the client.

(5) Case management services must be delivered by a case manager whose primary responsibility is the delivery of case management services to one or more of the populations identified in ARM 37.86.3306. Exceptions to this requirement may be approved by the department or its designee.

(6) Except as otherwise provided for in this subchapter, a client may select a case management service provider and other service providers whose services are received with the assistance of case management.

(7) A client in accordance with the following criteria may temporarily receive case management services from more than one case management service provider if:

(a) there is need for more than one case manager to manage the provision of services to the client;

(b) there is a single coordinated individualized plan for case management of the provision of services;

(c) there is a lead case management provider;

(d) there is an agreement as to which case management services provider will bill medicaid; and

(e) the plan of care contains the following:

(i) designation of the lead case management service provider;

(ii) justification for the use of more than one case management service provider;

(iii) specification of roles and responsibilities each case management service provider is to undertake;

(iv) documentation of all the case management services provided on behalf of the client, including those not reimbursed by medicaid;

(v) assurances of nonduplication of case management services; and

(vi) strategies for reducing case management to a single service provider.

(8) Medicaid reimbursement for case management services except as provided in ARM 37.86.3902, is only available for the case management services provided by the lead case management provider.

(9) Decisions as to which case management provider is to be the lead case management provider for a client, except as provided in ARM 37.86.3902, are made locally. If there is disagreement that cannot be resolved locally, the department contacts for each program involved are to make the necessary decision.

(10) A case management plan must be developed jointly by the case manager and the client and where appropriate the client's caregivers.

(a) The plan should be signed by the client and where appropriate the client's caregivers. If the plan is not signed, the reason for the lack of signature must be documented.

(b) Refusal to sign the plan will not result in a denial of case management services.

(c) A case management plan for a minor or for an adult who is subject to full guardianship must be signed by the parents or guardian. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1991 MAR p. 1295, Eff. 7/26/91; AMD, 1994 MAR p. 3201, Eff. 12/23/94; AMD, 1997 MAR p. 898, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481.)

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37.86.3306 CASE MANAGEMENT SERVICES, GENERAL ELIGIBILITY

(1) Persons who are medicaid recipients and are from the following groups are eligible for case management services:

(a) high risk pregnant women;

(b) adults with severe disabling mental illness;

(c) persons age 16 and over with developmental disabilities;

(d) youth with serious emotional disturbance;

(e) children at risk for abuse and neglect; and

(f) children with special health care needs. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1991 MAR p. 1295, Eff. 7/26/91; AMD, 1992 MAR p. 1248, Eff. 6/12/92; AMD, 1994 MAR p. 3201, Eff. 12/23/94; AMD, 1997 MAR p. 496, Eff. 3/11/97; AMD, 1997 MAR p. 898, Eff. 3/25/97; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481.)

Subchapter 34

Case Management Services for High
Risk Pregnant Women

37.86.3401 CASE MANAGEMENT SERVICES FOR HIGH RISK PREGNANT WOMEN, DEFINITIONS The definitions of case management services for high risk pregnant women are as follows:

(1) "Assessment" means an evaluation to identify a client's physical, medical, nutritional, psychosocial, developmental, and educational status to determine if the person meets the "high risk" criteria. This is an ongoing process updated at each contact.

(2) "Care coordination and referral" means helping a client to access services by establishing and maintaining a referral process for needed and appropriate services and avoiding duplication of services.

(3) "Case planning" means preparing a written service plan that reflects a client's needs and the resources available to meet those needs in a coordinated and integrated fashion.

(4) "Monitoring" means regular contacts to encourage cooperation and resolve problems which may create barriers to services and assuring that a client receives services as indicated in the service plan. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1991 MAR p. 1295, Eff. 7/26/91; AMD, 1997 MAR p. 496, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481.)

37.86.3402 CASE MANAGEMENT SERVICES FOR HIGH RISK PREGNANT WOMEN, ELIGIBILITY (1) A person is eligible for case management as a high risk pregnant woman if:

(a) the person is receiving medicaid or is presumptively eligible for medicaid; and

(b) the person's pregnancy outcome is considered to be at high risk as determined by the case manager.

(2) A pregnancy is of high risk if the person:

(a) is age 17 or younger;

(b) has medical factors which indicate the potential for a poor pregnancy outcome;

(c) or someone in the person's immediate environment abuses alcohol or drugs;

(d) is currently in an abusive relationship;

(e) is homeless; or

(f) demonstrates an inability to obtain necessary resources and services and the person meets 3 of the following criteria. The person:

(i) has a history of physical or sexual abuse;

(ii) has no support system or involvement of a spouse or other supporting person;

(iii) has 2 or more children under age 5;

(iv) is not educated beyond the 12th grade level;

(v) has a physical disability or mental impairment;

(vi) has had no prenatal care before or during the first 20 weeks of gestation;

(vii) is a refugee;

(viii) is age 18 or 19; or

(ix) has limited English proficiency.

(3) Case management services may be delivered to the client, if medicaid eligibility continues, until the last day of the month in which occurs the 60th day following the end of the pregnancy. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1991 MAR p. 1295, Eff. 7/26/91; AMD, 1997 MAR p. 496, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481.)

Rules 03 and 04 reserved

37.86.3405 CASE MANAGEMENT SERVICES FOR HIGH RISK PREGNANT WOMEN, COVERAGE (1) Reimbursable case management services for high risk pregnant women are:

(a) assessment;

(b) case plan development;

(c) care coordination and referral for other services; and

(d) monitoring. (History: Sec. 53-6-113, MCA; IMP, 53-6-101, MCA; NEW, 1991 MAR p. 1295, Eff. 7/26/91; TRANS, from SRS, 2000 MAR p. 481.)

Rules 06 through 09 reserved

37.86.3410 CASE MANAGEMENT SERVICES FOR HIGH RISK PREGNANT WOMEN, PROVIDER REQUIREMENTS (1) These requirements are in addition to those requirements contained in rule and statutory provisions generally applicable to medicaid providers.

(2) To be qualified as a provider of case management services for high risk pregnant women, an entity must:

(a) be approved by the department;

(b) meet the requirements in (3) through (7);

(c) have experience in the delivery of home and community services to high risk pregnant women;

(d) demonstrate an understanding of the concept of prenatal care coordination services; and

(e) have developed relationships with health care and other agencies in the area to be served.

(3) A case management provider must use an interdisciplinary team that includes members from the professions of nursing, social work and nutrition.

(a) The professional requirements for these professionals are the following:

(i) nursing must be provided by a licensed registered professional nurse who is either:

(A) a registered nurse with a bachelor of science degree in nursing, including course work in public health; or

(B) a certified nurse practitioner with 2 years experience in the care of families;

(ii) social work must be provided by a social worker with a masters or bachelors degree in behavioral sciences or related field with 1 year experience in community social services or public health. A social worker with a masters in social work (MSW), masters in counseling, or a bachelors in social work (BSW) with 2 years experience in community social services or public health is preferred; and

(iii) nutrition services must be provided by a registered dietitian who is licensed as a nutritionist in Montana and has 1 year experience in public health and/or maternal-child health.

(b) To accommodate special agency and geographic needs and circumstances, exceptions to the staffing requirements may be allowed if approved by the department.

(4) The case management provider must be able to provide the services of at least one of the professional disciplines listed in (3) directly. The other disciplines may be provided through subcontracts.

(5) Where services are provided through a subcontractor, the subcontract must be submitted to the department or designee for review and approval.

(6) A case management provider must:

(a) conduct activities to inform the target population and health care and social service providers in the geographic area to be served of its prenatal care coordination services;

(b) deliver prenatal care coordination services appropriate to the individual client's level of need;

(c) respond promptly to requests and referrals for targeted case management clients;

(d) perform assessments and develop care plans for the appropriate level of care and document services provided;

(e) schedule services to accommodate the client's situation;

(f) inform clients regarding whom and when to call for pregnancy emergencies;

(g) establish working relationships with medical providers, community agencies, and other appropriate organizations;

(h) assure that ongoing communication and coordination of client care occurs within the case management team and with the client's medical prenatal care provider;

(i) provide services in a home setting in addition to office or clinic settings. Home visiting, particularly by the community health nurse, is an integral part of targeted case management;

(j) have a system for handling client grievances; and

(k) maintain an adequate and confidential client records system. All services provided directly or through a subcontractor must be documented in this system.

(7) A case manager providing services for a case management provider must have:

(a) knowledge of:

(i) federal, state and local programs for children and pregnant women such as Title V programs, WIC, immunizations, perinatal health care, handicapped children's services, family planning, genetic services, hepatitis B screening, kids count (EPSDT), etc.;

(ii) individual health care plan development and evaluation;

(iii) community health care systems and resources; and

(iv) nationally recognized perinatal and child health care standards;

(b) the ability to:

(i) interpret medical findings;

(ii) develop an individual case management plan based on an assessment of a client's health, nutritional and psychosocial status and personal and community resources;

(iii) inform a client regarding health conditions and implications of risk factors;

(iv) encourage a client's responsibility for health care;

(v) establish linkages with service providers;

(vi) coordinate multiple agency services to the benefit of the client; and

(vii) evaluate a client's progress in obtaining appropriate medical care and other needed services. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1991 MAR p. 1295, Eff. 7/26/91; AMD, 1997 MAR p. 496, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481.)

37.86.3411 CASE MANAGEMENT SERVICES FOR HIGH RISK PREGNANT WOMEN, FINANCIAL RECORDS AND REPORTING (1) Services for high risk pregnant women delivered on an allowable cost basis are subject to the financial records and reporting requirements of this rule.

(2) A case management provider for high risk pregnant women must maintain adequate financial and statistical records, in the form and containing the information required by the department, to allow the department and its agents to determine payment for services provided to medicaid recipients and to provide a record that is auditable through the application of generally accepted audit procedures.

(3) Financial data must be maintained on an accrual basis. The provider must file a cost report for each of the provider's fiscal years.

(4) Financial records must be maintained for a period of six years, three months after a cost report is filed with respect to the period covered by the records or until the cost report is finally settled, whichever is later.

(5) The records described in (1) must be available at the facility at all reasonable times and shall be subject to inspection, review and audit by the department or its agents, the United States department of health and human services, the general accounting office, the Montana legislative auditor, and other appropriate governmental agencies.

(6) Upon failure or refusal of the provider to make available and allow access to such records or upon failure or refusal to submit a required cost report or upon submission of an inadequate cost report, the department may recover in full all payments made to the provider during the reporting period to which such records relate.

(7) Within 90 days after the end of the provider's fiscal year, the provider must submit to the department or its agent in the form and detail required by the department, a cost report covering the reporting period and containing the following information:

(a) the allowable costs actually incurred in providing case management services for the period and the actual number of services provided during the period; and

(b) the amounts of all payments received or due from other payors, including but not limited to medicare and private insurers, with respect to such services.

(8) Overpayments and underpayments are collected or paid as provided in ARM 37.86.2803 and references in that rule to a "hospital" shall be deemed to be references to a case management provider.

(9) A provider who is aggrieved by the department's interim rate determination, determination of overpayment or underpayment, or other adverse determination may request an administrative review or fair hearing in accordance with the requirements and procedures of ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337. (History: Sec. 53-6-113, MCA; IMP, Sec. 2-4-201, 53-2-201, 53-2-606, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 1295, Eff. 7/26/91; AMD, 1992 MAR p. 1496, Eff. 7/17/92; AMD, 1996 MAR p. 1566, Eff. 6/7/96; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00; AMD, 2004 MAR p. 482, Eff. 2/27/04.)

Rules 12 through 14 reserved

37.86.3415 CASE MANAGEMENT SERVICES FOR HIGH RISK PREGNANT WOMEN, REIMBURSEMENT (1) Case management services for high risk pregnant women provided on or after January 1, 1996 are reimbursed at the lower of the following:

(a) the provider's customary charge for the service; or

(b) $6.00 for each 15 minutes of service.

(2) Case management services for high risk pregnant women provided prior to January 1, 1996 are reimbursed, in accordance with (2)(a) through (2)(d), for the allowable costs of providing case management services to eligible medicaid recipients.

(a) The amount of reimbursement due a provider will be determined retrospectively by the department based upon the reporting period cost report required under ARM 37.86.3411. An overpayment or underpayment for the reporting period is calculated by finding the difference between the total of the incurred allowable costs reported and the total of the interim payments received by the provider. The department will notify the provider in writing of any overpayment or underpayment determination.

(b) The department will establish interim rates for each service. An interim rate will be determined for a fiscal year by dividing the estimated total allowable costs on a statewide basis for the service during the fiscal year by estimated total of service units to be delivered on a statewide basis during that fiscal year.

(i) The department may, but is not required to, review and adjust the interim rates established during the reporting period to assure that interim payments approximate allowable costs for case management services if:

(A) there is a significant change in the utilization of case management services;

(B) the incurred allowable costs vary materially from the estimated allowable costs; or

(C) the department in its discretion determines that other circumstances warrant an adjustment.

(c) No cost shall be allowable unless the department determines that it has been incurred and that it is reasonable and necessarily related to the provision of case management services. Profit is not an allowable cost.

(d) Reimbursement shall not exceed the provider's customary charge to the general public for the service. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1991 MAR p. 1295, Eff. 7/26/91; AMD, 1996 MAR p. 1997, Eff. 6/7/96; TRANS, from SRS, 2000 MAR p. 481.)

Subchapter 35

Case Management Services for Adults with
Severe Disabling Mental Illness

37.86.3501 CASE MANAGEMENT SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS, DEFINITIONS (1) "Assessment" means an integrated examination of the client's strengths, status, aspirations, needs and goals in the life domains of residence, health, vocation, education, community participation, leisure time and economics.

(2) "Assistance in daily living" means the ongoing monitoring of how a client is coping with life on a day-to-day basis and the activities a case manager performs which support a client in daily life. Assistance with daily living skills includes, but is not limited to, assistance with shopping, monitoring symptoms related to medications, assistance with budgeting, teaching use of public transportation, monitoring and tutoring with regard to health maintenance, and monitoring contact with the family members.

(3) "Case planning" means the development of a written individualized case management plan by the case manager and the client.

(4) "Coordination, referral, and advocacy" means providing access to and mobilizing resources to meet the needs of a client. This may include but is not limited to:

(a) advocating on behalf of a client with a local human services system, the social security system, the disability determination unit, judges, etc.;

(b) making appropriate referrals, including to advocacy organizations and service providers, and insuring that needed services are provided; and

(c) intervening on behalf of a client who otherwise could not negotiate or access complex systems without assistance and support.

(5) "Crisis response" means immediate action by an intensive case manager or care coordination case manager for the purpose of supporting or assisting a client or other person in response to a client's mental health crisis. Crisis response must be made in a manner consistent with the least restrictive alternative measures or settings available for the client's condition. Crisis response may include contact with a client's family members if necessary and appropriate.

(6) "Episode of decompensation" means increased symptoms of psychosis, self-injury, suicidal or homicidal intent or psychiatric hospitalization.

(7) "Severe disabling mental illness" means with respect to a person who is 18 or more years of age that the person meets the requirements of (7)(a), (b) or (c). The person must also meet the requirements of (7)(d). The person:

(a) has been involuntarily hospitalized for at least 30 consecutive days because of a mental disorder at Montana state hospital (Warm Spring campus) at least once;

(b) has a DSM-IV diagnosis of:

(i) schizophrenic disorder (295);

(ii) other psychotic disorder (293.81, 293.82, 295.40, 295.70, 297.1, 297.3, 298.9);

(iii) mood disorder (293.83, 296.2x, 296.3x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89);

(iv) amnestic disorder (294.0, 294.8);

(v) disorder due to a general medical condition (310.1);

(vi) pervasive developmental disorder not otherwise specified (299.80) when not accompanied by mental retardation; or

(vii) anxiety disorder (300.01, 300.21, 300.3);

(c) has a DSM-IV diagnosis of personality disorder (301.00, 301.20, 301.22, 301.4, 301.50, 301.6, 301.81, 301.82, 301.83, or 301.90) which causes the person to be unable to work competitively on a full-time basis or to be unable to maintain a residence without assistance and support by family or a public agency for a period of at least six months or is obviously predictable to continue for a period of at least six months; and

(d) has ongoing functioning difficulties because of the mental illness for a period of at least six months or for an obviously predictable period over six months, as indicated by at least two of the following:

(i) a medical professional with prescriptive authority has determined that medication is necessary to control the symptoms of mental illness;

(ii) the person is unable to work in a full-time competitive situation because of mental illness;

(iii) the person has been determined to be disabled due to mental illness by the social security administration; or

(iv) the person maintains a living arrangement only with ongoing supervision, is homeless, or is at imminent risk of homelessness due to mental illness; or

(v) the person has had or will predictably have repeated episodes of decompensation. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2004 MAR p. 84, Eff. 1/1/04.)

37.86.3502 CASE MANAGEMENT SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS, ELIGIBILITY (1) Case management services are available under ARM 37.86.3501, 37.86.3502, 37.86.3504, 37.86.3506, 37.86.3507 and 37.86.3515 only to adults (age 18 or over) with severe disabling mental illness. (History: Sec. 53-2-201, 53-6-113 and 53-21-703, MCA; IMP, Sec. 53-6-101 and 53-21-701, MCA; NEW, 1999 MAR p. 1806, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2001 MAR p. 989, Eff. 6/8/01; EMERG, AMD, 2002 MAR p. 3417, Eff. 12/1/02; AMD, 2003 MAR p. 653, Eff. 3/28/03; AMD, 2004 MAR p. 84, Eff. 1/1/04.)

Rules 03 and 04 reserved

37.86.3505 CASE MANAGEMENT SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS, SERVICE COVERAGE (1) Case management services for adults with severe and disabling mental illness include:

(a) assessment;

(b) case planning;

(c) assistance in daily living;

(d) coordination, referral and advocacy; and

(e) crisis response.

(2) Intensive case management services for adults with severe disabling mental illness are case management services provided by a licensed mental health center in accordance with these rules and the provisions of Title 50, chapter 5, part 2, MCA.

(3) Care coordination case management services for adults with severe disabling mental illness are case management services, as specified in (1), provided in accordance with these rules by a licensed mental health center. Care coordination case management services may include telephone services. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; EMERG, AMD, 2002 MAR p. 1328, Eff. 4/26/02.)

37.86.3506 CASE MANAGEMENT SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS, SERVICE REQUIREMENTS (1) Case management services must be supported by narrative documentation of all services provided.

(2) Case management services for adults with severe disabling mental illness must be provided according to a case management plan which must:

(a) be developed jointly by the case manager and the client;

(b) identify measurable objectives;

(c) specify strategies to achieve defined objectives;

(d) identify agencies and contacts which will assist in meeting the objectives;

(e) identify natural and community supports to be utilized and developed; and

(f) include an objective to serve the client in the least restrictive and most culturally appropriate therapeutic environment possible for the client which is also directed toward facilitating preservation of the client in the family unit, or preventing out-of-community placement or facilitating the client's return from acute or residential psychiatric care.

(3) Objectives in a case management plan must have an identified date of review no more than 90 days after the plan date. Plans will be revised to reflect changes in client goals and needs, and the services provided to the client.

(4) Case management services for adults with severe disabling mental illness must be delivered in accordance with the individual recipient's needs. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; EMERG, AMD, 2003 MAR p. 1087, Eff. 5/23/03.)

37.86.3507 CASE MANAGEMENT SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS, PROVIDER REQUIREMENTS (1) These requirements are in addition to those requirements contained in rules generally applicable to medicaid providers.

(2) Case management services for adults with severe disabling mental illness must be provided by a licensed mental health center:

(a) with a license endorsement permitting the mental health center to provide intensive case management services to the population being served; and

(b) enrolled in the Montana medicaid program as a case management services provider. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; EMERG, AMD, 2002 MAR p. 1328, Eff. 4/26/02; EMERG, AMD, 2003 MAR p. 1087, Eff. 5/23/03.)

Rules 08 through 14 reserved

37.86.3515 CASE MANAGEMENT SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS, REIMBURSEMENT (1) Case management services for adults with severe disabling mental illness will be reimbursed on a fee per unit of service basis. For purposes of this rule, a unit of service is a period of 15 minutes.

(2) Group care coordination services may not exceed a maximum of eight participants per group.

(3) The department may, in its discretion, designate a single provider to provide intensive case management services in a designated geographical region. Any provider designated as the sole intensive case management provider for a designated geographical region must, as a condition of such designation, agree to serve the entire designated geographical region.

(4) The department will pay the lower of the following for case management services for adults with severe disabling mental illness:

(a) the provider's actual submitted charge for services; or

(b) the amount specified in the department's medicaid mental health fee schedule adopted in ARM 37.86.2207. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; EMERG, AMD, 2002 MAR p. 1328, Eff. 4/26/02; EMERG, AMD, 2003 MAR p. 1087, Eff. 5/23/03.)

Subchapter 36

Case Management Services for Persons Age 16 and Over with Developmental Disabilities

37.86.3601 CASE MANAGEMENT SERVICES FOR PERSONS AGE 16 AND OVER WITH DEVELOPMENTAL DISABILITIES, DEFINITIONS The definitions of case management services for persons with developmental disabilities age 16 years of age and over are as follows:

(1) "Developmental disability" means a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or any other neurological handicapping condition closely related to mental retardation and requiring treatment similar to that required by mentally retarded persons if the disability originated before the person attained age 18, has continued or can be expected to continue indefinitely, and constitutes a substantial handicap of the person.

(2) "Developmental disabilities program" means the program of services administered by the department for persons with developmental disabilities.

(3) "Intermediate care facility for the mentally retarded (ICF/MR)" means a residential facility as defined at 42 USC 1396d(d) and licensed by the Montana department of public health and human services to provide active treatment services to persons with developmental disabilities.

(4) "Nursing facility" means a residential facility as defined at 42 USC 1396r(a) and licensed by the Montana department of public health and human services to provide nursing services.

(5) "Monitor" means periodic review of the implementation of services identified in the individual plan.

(6) "Individual plan (IP)" means a written plan developed with the client's participation for the provision and management of services in the least restrictive manner to recipients. The plan must contain:

(a) reference to all provided services including identification of providers;

(b) documentation of who was involved in developing the plan;

(c) long range services and goals;

(d) short term services and objectives;

(e) schedules for service initiation and frequency; and

(f) schedules for updating the plan. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1991 MAR p. 1295, Eff. 7/26/91; AMD, 1994 MAR p. 3201, Eff. 12/23/94; AMD, 1997 MAR p. 496, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481.)

37.86.3602 CASE MANAGEMENT SERVICES FOR PERSONS AGE 16 AND OVER WITH DEVELOPMENTAL DISABILITIES, ELIGIBILITY (1) A person is eligible for case management as a person with developmental disabilities if the person:

(a) is receiving medicaid;

(b) is 16 years of age or over; and

(c) has a developmental disability.

(2) Case management services are not available to:

(a) a person residing in an intermediate care facility for the mentally retarded (ICF/MR) or in a medicaid certified nursing facility except as provided for in (3); or

(b) a person receiving case management services under a home and community-based waiver program authorized under section 1915 (c) of the Social Security Act.

(3) A person residing in a medicaid certified nursing facility or intermediate care facility for the mentally retarded (ICF/MR) may receive case management services during the 30 day period immediately preceding the scheduled discharge from a nursing facility in order to coordinate postdischarge services in a non-institutional setting. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1991 MAR p. 1295, Eff. 7/26/91; AMD, 1994 MAR p. 3201, Eff. 12/23/94; AMD, 1997 MAR p. 496, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481.)

Rules 03 and 04 reserved

37.86.3605 CASE MANAGEMENT SERVICES FOR PERSONS AGE 16 AND OVER WITH DEVELOPMENTAL DISABILITIES, COVERAGE (1) Reimbursable case management services for persons age 16 and over with developmental disabilities are:

(a) service coordination which includes the following:

(i) assessment and evaluation of the appropriateness and need for case management and other community services for which the client might be eligible;

(ii) assistance in accessing and obtaining needed services as requested by the client;

(iii) assisting the client's entry into services; and

(iv) monitoring and follow up services received by the client.

(b) planning which includes the following:

(i) development, facilitation, coordination, and monitoring of an individual plan (IP) for the client.

(c) crisis intervention which includes the following:

(i) crisis intervention for personal, financial, social, legal or medical crisis; and

(ii) preventative problem solving with the client and where appropriate the client's family to prevent a crisis.

(d) quality of life which includes the following:

(i) building of personal relationship, communication, trust and a basic understanding of the client as a unique human being by establishing a rapport with the client and the client's family and friends;

(ii) getting an understanding for how the client is doing or for how client wants to be doing; and

(iii) conducting a quality of life assessment for the client.

(2) Case management services for persons age 16 and over with developmental disabilities are available without geographic limitation. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1991 MAR p. 1295, Eff. 7/26/91; AMD, 1994 MAR p. 3201, Eff. 12/23/94; AMD, 1997 MAR p. 496, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481.)

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37.86.3606 CASE MANAGEMENT SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, PROVIDER REQUIREMENTS (1) These requirements are in addition to those contained in rule and statutory provisions generally applicable to medicaid providers.

(2) The case management provider for persons age 16 and over with developmental disabilities is the developmental disabilities program of the department. The program may contract for the delivery of case management services.

(3) Contractors with the program for the provision of case management services must be either accredited by one of the national accreditation agencies for developmental disabilities services specified in ARM 37.34.1801 or licensed under 50-5-201, MCA as a health care facility by the department.

(4) A case manager must be employed by the developmental disabilities program of the department or by a case management provider contracting with the program.

(5) A case manager must meet the following criteria:

(a) A case manager, except as otherwise provided for in (5)(b), must:

(i) have a bachelor's degree in social work or a related field from an accredited college; and

(ii) 1 year experience in developmental disabilities or other human services:

(A) if the experience is in a human service other than developmental disabilities, the case manager must have completed at least 40 hours of training in the delivery of services to persons with developmental disabilities under a training curriculum reviewed by the developmental disabilities program of the department within no more than 3 months of hire or designation as a case manager.

(6) All services provided to the client will be monitored by the case manager and the case manager's supervisor. The IP will be reviewed and revised according to the client's needs at least annually, or when major changes are needed.

(7) A provider of direct care services to persons with developmental disabilities may not act as the case management provider for clients for whom the provider delivers services.

(8) A case manager must participate in a minimum of 20 hours of advanced training in services to persons with developmental disabilities each year under a training curriculum reviewed by the developmental disabilities program of the department. On-going documentation of the qualifications of case managers and completions of mandated training must be maintained by the employer of the case manager.

(9) A case management provider must:

(a) have a system for handling client grievances; and

(b) protect the confidentiality of client records. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1991 MAR p. 1295, Eff. 7/26/91; AMD, 1994 MAR p. 3201, Eff. 12/23/94; AMD, 1997 MAR p. 496, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481.)

37.86.3607 CASE MANAGEMENT SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, REIMBURSEMENT (1) Reimbursement for targeted case management services for persons with developmental disabilities is provided to the developmental disabilities program of the department in accordance with (2) through (4).

(a) This rule does not govern reimbursement provided to contract providers of case management services for the developmental disabilities program of the department.

(2) A unit of service is 1 contact in person or otherwise with or on behalf of the client.

(3) The interim reimbursement for each fiscal year is based on a per unit of service rate determined by dividing the estimated total costs on a statewide basis for the delivery of case management services for the fiscal year by the estimated total number of units of service to be delivered on a statewide basis during that fiscal year.

(4) The final reimbursement for each fiscal year is the actual total cost for delivery of the service for the fiscal year. (History: Sec. 56-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1991 MAR p. 1295, Eff. 7/26/91; AMD, 1994 MAR p. 3201, Eff. 12/23/94; AMD, 1997 MAR p. 496, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481.)

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Subchapter 37

Case Management Services for Youth with
Serious Emotional Disturbance

37.86.3701 CASE MANAGEMENT SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE, DEFINITIONS (1) "Assessment" means the act of identifying the resources and services needed to carry out the therapeutic case plan. Assessment includes identifying the strengths, abilities, potentials, skills and aspirations of the client and the client's family. This is not a psychiatric, medical or other specialized evaluation which is traditionally completed by other qualified professionals. Assessment enables the case manager to determine the nature and extent of brokering, coordination, transportation and advocacy needed.

(2) "Assistance in daily living" means the ongoing monitoring of how a client is coping with life on a day-to-day basis and the provision of assistance by a case manager which supports a client in daily life. Assistance with daily living skills includes but is not limited to:

(a) assistance with shopping and budgeting;

(b) teaching use of public transportation and other resources;

(c) monitoring and tutoring with regard to health maintenance; and

(d) monitoring contact with family members.

(3) "Case planning" means the development of a written individualized case management plan for the client which is arrived at by the case manager with the participation of:

(a) the parent, legal guardian, or the surrogate parent;

(b) the client advocate;

(c) the client; and

(d) the client's service providers.

(4) "Coordination, referral and advocacy" means providing access to and mobilizing resources to meet the needs of the client. This may include but is not limited to:

(a) monitoring and assessing the impact of services being provided;

(b) identifying services included in the case plan that are not currently being provided, and the reasons the services are not being provided;

(c) ensuring that services identified in the case plan are provided;

(d) making appropriate referrals, including to advocacy organizations and service providers;

(e) enhancing parent or surrogate parent involvement in the planning and delivery of services for a client;

(f) empowering the client to speak or act on the client's own behalf when possible; and

(g) speaking or acting on the client's behalf when the client or others are unable to carry out this role.

(5) "Crisis response" means immediate action by an intensive case manager or care coordination case manager for the purpose of supporting or assisting a client or other person in response to a client's mental health crisis. Crisis response must be made in a manner consistent with the least restrictive alternative measures or settings available for the client's condition. Crisis response may include contact with a client's family members if necessary and appropriate. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481.)

37.86.3702 CASE MANAGEMENT SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE, ELIGIBILITY (1) Case management services are available under ARM 37.86.3701, 37.86.3702, 37.86.3705, 37.86.3706, 37.86.3707 and 37.86.3715 only to youth with serious emotional disturbance.

(2) "Serious emotional disturbance (SED)" means with respect to a youth between the ages of 6 and 17 years that the youth meets requirements of (2)(a) and either (2)(b) or (2)(c).

(a) The youth has been determined by a licensed mental health professional as having a mental disorder with a primary diagnosis falling within one of the following DSM-IV (or successor) classifications when applied to the youth's current presentation (current means within the past 12 calendar months unless otherwise specified in the DSM-IV) and the diagnosis has a severity specifier of moderate or severe:

(i) childhood schizophrenia (295.10, 295.20, 295.30, 295.60, 295.90);

(ii) oppositional defiant disorder (313.81);

(iii) autistic disorder (299.00);

(iv) pervasive developmental disorder not otherwise specified (299.80);

(v) asperger's disorder (299.80);

(vi) separation anxiety disorder (309.21);

(vii) reactive attachment disorder of infancy or early childhood (313.89);

(viii) schizo affective disorder (295.70);

(ix) mood disorders (296.0x, 296.2x, 296.3x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89);

(x) obsessive-compulsive disorder (300.3);

(xi) dysthymic disorder (300.4);

(xii) cyclothymic disorder (301.13);

(xiii) generalized anxiety disorder (overanxious disorder) (300.02);

(xiv) posttraumatic stress disorder (chronic) (309.81);

(xv) dissociative identity disorder (300.14);

(xvi) sexual and gender identity disorder (302.2, 302.3, 302.4, 302.6, 302.82, 302.83, 302.84, 302.85, 302.89);

(xvii) anorexia nervosa (severe) (307.1);

(xviii) bulimia nervosa (severe) (307.51);

(xix) intermittent explosive disorder (312.34); and

(xx) attention deficit/hyperactivity disorder (314.00, 314.01, 314.9) when accompanied by at least one of the diagnoses listed above.

(b) As a result of the youth's diagnosis determined in (2)(a) and for a period of at least 6 months, or for a predictable period over 6 months the youth consistently and persistently demonstrates behavioral abnormality in two or more spheres, to a significant degree, well outside normative developmental expectations, that cannot be attributed to intellectual, sensory, or health factors:

(i) has failed to establish or maintain developmentally and culturally appropriate relationships with adult care givers or authority figures;

(ii) has failed to demonstrate or maintain developmentally and culturally appropriate peer relationships;

(iii) has failed to demonstrate a developmentally appropriate range and expression of emotion or mood;

(iv) has displayed disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic or recreation settings;

(v) has displayed behavior that is seriously detrimental to the youth's growth, development, safety or welfare, or to the safety or welfare of others; or

(vi) has displayed behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment.

(c) In addition to mental health services, the youth demonstrates a need for specialized services from at least one of the following human service systems during the previous 6 months:

(i) education services, due to the diagnosis determined in (a), as evidenced by identification as a child with a disability as defined in 20-7-401(4), MCA with respect to which the youth is currently receiving special education services;

(ii) child protective services as evidenced by temporary investigative authority, or temporary or permanent legal custody;

(iii) the juvenile correctional system, due to the diagnosis determined in (2)(a), as evidenced by a youth court consent adjustment or consent decree or youth court adjudication; or

(iv) current alcohol/drug abuse or addiction services as evidenced by participation in treatment through a state-approved program or with a certified chemical dependency counselor.

(d) Serious emotional disturbance (SED) with respect to a youth under 6 years of age means the youth exhibits a severe behavioral abnormality that cannot be attributed to intellectual, sensory, or health factors and that results in substantial impairment in functioning for a period of at least 6 months and obviously predictable to continue for a period of at least 6 months, as manifested by one or more of the following:

(i) atypical, disruptive or dangerous behavior which is aggressive or self-injurious;

(ii) atypical emotional responses which interfere with the child's functioning, such as an inability to communicate emotional needs and to tolerate normal frustrations;

(iii) atypical thinking patterns which, considering age and developmental expectations, are bizarre, violent or hypersexual;

(iv) lack of positive interests in adults and peers or a failure to initiate or respond to most social interaction;

(v) indiscriminate sociability (e.g., excessive familiarity with strangers) that results in a risk of personal safety of the child; or

(vi) inappropriate and extreme fearfulness or other distress which does not respond to comfort by care givers. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2001 MAR p. 989, Eff. 6/8/01.)

Rules 03 and 04 reserved

NEXT PAGE IS 37-20701

37.86.3705 CASE MANAGEMENT SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE, SERVICE COVERAGE (1) Case management services for youth with serious emotional disturbance include:

(a) assessment;

(b) case planning;

(c) assistance in daily living;

(d) coordination, referral and advocacy; and

(e) crisis response.

(2) Case management services for youth with serious emotional disturbance are provided by a licensed mental health center in accordance with these rules and the provisions of Title 50, chapter 5, part 2, MCA, and implementing rules. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; EMERG, AMD, 2002 MAR p. 1328, Eff. 4/26/02; EMERG, AMD, 2003 MAR p. 1087, Eff. 5/23/03.)

37.86.3706 CASE MANAGEMENT SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE, SERVICE REQUIREMENTS (1) Case management services for youth with serious emotional disturbance must be supported by narrative documentation of all services provided.

(2) Case management services for youth with serious emotional disturbance must be provided according to a case management plan which must:

(a) identify and define measurable objectives for the client and the client's family;

(b) include an objective to serve the client in the least restrictive and most culturally appropriate therapeutic environment possible for the client which is also directed toward facilitating preservation of the client in the family unit, or preventing out-of-community placement or facilitating the client's return from acute or residential psychiatric care;

(c) specify strategies for achieving defined objectives;

(d) identify the strengths and potentials of the client and the client's family which will be a base upon which coordinated services will be provided;

(e) identify agencies, service providers and contacts which will assist in achieving the defined objectives and specify how they will assist;

(f) identify natural, family and community supports to be utilized and developed in achieving the defined objectives;

(g) identify the role and duties of the client, the parent or the surrogate parent and all participants in the delivery of a comprehensive and coordinated service to the client and the client's family; and

(h) specify monitoring procedures and time frames.

(3) Objectives in a case management plan must have an identified date of review no more than every 90 days after the plan date. Plans must be kept current and revised to reflect changes in client goals and needs, the services provided to the client, and provider changes of responsibility.

(4) Case management services for youth with serious emotional disturbance must be delivered in accordance with the individual recipient's needs. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; EMERG, AMD, 2003 MAR p. 1087, Eff. 5/23/03.)

37.86.3707 CASE MANAGEMENT SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE, PROVIDER REQUIREMENTS (1) These requirements are in addition to those contained in provisions generally applicable to medicaid providers.

(2) Case management services for youth with serious emotional disturbance must be provided by a licensed mental health center:

(a) with a license endorsement permitting the mental health center to provide intensive case management services to the population being served;

(b) enrolled in the Montana medicaid program as a case management services provider; and

(c) contracted with the department to provide case management services for youth with serious emotional disturbance. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; EMERG, AMD, 2002 MAR p. 1328, Eff. 4/26/02; EMERG, AMD, 2003 MAR p. 1087, Eff. 5/23/03.)

Rules 08 through 14 reserved

NEXT PAGE IS 37-20723

37.86.3715 CASE MANAGEMENT SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE, REIMBURSEMENT (1) Case management services for youth with serious emotional disturbance will be reimbursed on a fee per unit of service basis. For purposes of this rule, a unit of service is a period of 15 minutes.

(2) Group care coordination services may not exceed a maximum of eight participants per group.

(3) The department may, in its discretion, designate a single provider to provide case management services in a designated geographical region. Any provider designated as the sole case management provider for a designated geographical region must, as a condition of such designation, agree to serve the entire designated geographical region.

(4) The department will pay the lower of the following for case management services for youth with serious emotional disturbance:

(a) the provider's actual submitted charge for services; or

(b) the amount specified in the department's medicaid mental health fee schedule adopted in ARM 37.86.2207. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; EMERG, AMD, 2002 MAR p. 1328, Eff. 4/26/02; EMERG, AMD, 2003 MAR p. 1087, Eff. 5/23/03.)

Subchapter 38

Case Management Services for Children
at Risk of Abuse and Neglect

37.86.3801 CASE MANAGEMENT SERVICES FOR CHILDREN AT RISK OF ABUSE AND NEGLECT, DEFINITIONS The definitions of case management services for children at risk of abuse and neglect are as follows:

(1) "Assessment" means an evaluation of a child's physical, medical, nutritional, psychological, social, developmental and educational status in the context of the child's caretakers to determine if the child meets the "at risk" criteria stated in ARM 37.86.3806 and to document the child's needs for resources and services. The assessment is updated at each contact.

(2) "Care coordination and referral" means helping a child and child's caretakers to access services by establishing and maintaining a referral process for needed and appropriate services and by avoiding duplication of services.

(3) "Case plan" means a written service plan based on an assessment reflecting a child's needs and strengths. The plan provides goals of intervention, objectives and activities in context of the child's caretakers, and identifies the resources and services available to meet the child's needs in a coordinated and integrated fashion.

(4) "Monitoring" means regular contacts to encourage cooperation, to identify and resolve problems which may create barriers to services, and to assure the receipt of services as indicated in the case plan. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1997 MAR p. 496, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481.)

Rules 02 through 04 reserved

37.86.3805 CASE MANAGEMENT SERVICES FOR CHILDREN AT RISK OF ABUSE AND NEGLECT, COVERAGE (1) The following services are reimbursable case management services for children at risk of abuse or neglect:

(a) assessment;

(b) case plan development;

(c) care coordination and referral; and

(d) monitoring. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1997 MAR p. 496, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481.)

37.86.3806 MEDICAID REIMBURSED CASE MANAGEMENT SERVICES FOR CHILDREN AT RISK OF ABUSE AND NEGLECT, ELIGIBILITY (1) A child is eligible for medicaid reimbursed case management services for children at risk of abuse or neglect if the child is:

(a) 12 years or younger;

(b) at risk of abuse or neglect but is not at risk of immediate removal from the home; and

(c) not receiving case management services from any other case management providers.

(2) A child is at risk of abuse or neglect if:

(a) a provider of children at risk of abuse or neglect case management services determines the child to be at risk of abuse or neglect; and

(b) the child:

(i) has been referred to the child protective services program of the department based on the determination; or

(ii) even though not referred to the department, has high potential for abuse as indicated by the standardized partnership to strengthen families' risk referral (form PSF-01) and as verified by a partnership provider through the standardized assessment process utilizing the family life survey (form PSF-20), the life experiences survey (form PSF-21), and the basic family needs survey (PSF-23). The department adopts and incorporates by reference the PSF forms referred to in this rule. A copy of the forms may be obtained from the Department of Public Health and Human Services, Child and Family Services Division, 1400 Broadway, P.O. Box 8005, Helena, MT 59620-8005. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1997 MAR p. 496, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481; AMD, 2004 MAR p. 1404, Eff. 6/18/04.)

Rules 07 through 09 reserved

37.86.3810 MEDICAID REIMBURSED CASE MANAGEMENT SERVICES FOR CHILDREN AT RISK OF ABUSE AND NEGLECT, PROVIDER REQUIREMENTS

(1) These requirements are in addition to those requirements contained in ARM Title 37, chapter 85, subchapter 4 and Title 53, chapter 6, MCA, as applicable to medicaid providers.

(2) Case management providers for children at risk of abuse and neglect include:

(a) the department's child and family services division (CFSD); or

(b) a case management agency under contract with CFSD.

(3) A case management agency under contract with CFSD, to provide in-home services must:

(a) have the capacity to provide assessment, case coordination and referral, and case plan development and monitoring;

(b) have a signed collaborative agreement with the child protective services program of the department and other key child and family services organizations in the county or counties where case management is being provided, such as the county health department, county extension services, the community mental health programs, county public schools, and private child and family services organizations in order to avoid duplication of services and to promote effective community level networking;

(c) be available to clients in crisis on a 24-hour basis and be able to identify a crisis situation and respond accordingly;

(d) employ case managers who have at least a two year degree in human services from an accredited institution or at least two years experience in a related field;

(e) must seek approval from the department for any exceptions to the staff requirements. The department has the discretion to approve exceptions to the staffing requirements based on special circumstances; and

(f) employ a case management supervisor who:

(i) holds a masters degree, bachelors degree, or relevant professional certification in a related health or human service field; and

(ii) has at least five years of relevant experience. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1997 MAR p. 496, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481; AMD, 2004 MAR p. 1404, Eff. 6/18/04.)

37.86.3811 MEDICAID REIMBURSED CASE MANAGEMENT SERVICES FOR CHILDREN AT RISK OF ABUSE AND NEGLECT, REIMBURSEMENT

(1) Contracted agencies providing case management services to children at risk of abuse and neglect are reimbursed at the lower of the following:

(a) the providers customary charge to the general public for the service; or

(b) $6.72 for each 15 minutes of service.

(2) Case management services provided by the CFSD for children at risk of abuse and neglect is a monthly rate established for each state fiscal year. The monthly rate is determined on a statewide basis on July 1 of each year by dividing the average monthly costs for the delivery of case management services for the previous year by the average monthly service population for the previous year.

(3) A unit of service is any targeted case management service provided during the month to a medicaid eligible child by the social worker employed by the department.

(4) Only one unit of service per month per medicaid eligible child can be billed. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1997 MAR p. 496, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481; AMD, 2004 MAR p. 1404, Eff. 6/18/04.)

Subchapter 39

Case Management Services for Children
with Special Health Care Needs

37.86.3901 CASE MANAGEMENT SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS, DEFINITIONS The definitions of case management services for children with special health care needs are as follows:

(1) "Assessment" means an evaluation of a child's physical, medical, nutritional, psychological, social, developmental, and educational status in the context of the child's caretakers to determine if the child meets the "at risk" criteria stated in ARM 37.86.3902 or if the child has diagnosed special health care needs, and to document the child's needs for resources and services.

(2) "Case plan" means a written, individualized, family-centered, culturally competent and coordinated case management service plan reflecting a child's needs and strengths. The plan provides goals of intervention, objectives, activities in context of the child's caregivers, and the resources and services available to meet the child's needs in a coordinated and integrated fashion.

(3) "Care coordination and referral" means assisting a child and child's caregivers to access resources and services, including children's special health services, specialty clinics, other needed services, and to establish and maintain eligibility for services other than medicaid. For those children for whom the developmental disabilities family education and support services program (DDFESS) retains lead status, care coordination activities are determined at the community level.

(4) "Developmental disabilities family education and support services (DDFESS)" means the developmental disabilities family education and support services program comprised of the federally authorized and funded Part H services, state funded family education and support services.

(5) "Monitoring" means regular contacts through ongoing home visitation and other means to assure appropriateness of services provided to the child and the child's caregivers, to identify and address concerns which may create barriers to services, and to assure the receipt of services as indicated in the case plan. Health and medical services for children served by DDFESS may be monitored by the children with special health care needs. Program monitoring functions include:

(a) utilizing information obtained from assessments of the child/family's needs and status; and

(b) modifying the case management service plan as needed in coordination with all involved providers in order to promote positive outcomes for a child and the child's caregivers. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1997 MAR p. 496, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481.)

37.86.3902 CASE MANAGEMENT SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS, ELIGIBILITY (1) A child is eligible for case management services for children with special health care needs if:

(a) the child:

(i) is birth through 18 years of age;

(ii) is diagnosed with special health care needs or at risk for chronic physical, developmental, behavioral, or emotional conditions; and

(iii) requires health and related services of a type or amount beyond that required by children of the same age; or

(b) the child is born to a woman who received case management services as a high risk pregnant woman.

(2) For a child who is eligible for developmental disabilities Part H services or for developmental disabilities family and educational support general fund services and who is eligible for children with special health care needs case management, the developmental disabilities services program provides lead case management. For a child with case management services from both the developmental disabilities program and the children's special health care needs program, the case management services provided by children with special health care needs case management providers are limited to the coordination of health and medical activities only. Children with special health care needs case management providers must incorporate the health and medical care plan within the individual family service plan and provide services in accordance with ARM 37.34.601, 37.34.602, 37.34.604, 37.34.605, 37.34.609, 37.34.612 through 37.34.616, 37.34.621, 37.34.622, 37.34.2101, 37.34.2102, 37.34.2106, 37.34.2107, 37.34.2111 and 37.34.2112. Under these circumstances, children with special health care needs case management providers may bill medicaid for health and medical case management activities only.

(3) Initial assessment of children covered by these special health care needs case management services may occur in the hospital following the infant's birth. This assessment must be followed by a referral to appropriate service providers in the community. Assessments by all professionals will be accepted, shared, and integrated into planning for all children covered by these services. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1997 MAR p. 496, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481.)

Rules 03 and 04 reserved

37.86.3905 CASE MANAGEMENT SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS, COVERAGE (1) The following services are reimbursable case management services for children with special health care needs:

(a) assessment;

(b) case planning;

(c) care coordination and referral; and

(d) monitoring. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1997 MAR p. 496, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481.)

37.86.3906 CASE MANAGEMENT SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS, PROVIDER REQUIREMENTS (1) These requirements are in addition to those contained in rule and statutory provisions generally applicable to medicaid providers.

(2) To be qualified as a provider of case management services for children with special health care needs, an entity must:

(a) be a provider of public health nursing or social work services;

(b) be approved by the department's health policy and services division;

(c) have knowledge and experience in the delivery of home and community services to children with special health care needs;

(d) demonstrate an understanding of service coordination for young children up to 18 years of age;

(e) have developed collaborative working relationships with health care and other providers in the area to be served;

(f) have access to multi-disciplinary providers; and

(g) have on file with the department's health policy and services division, a signed collaborative agreement with community providers of services for children with special health care needs that includes at a minimum:

(i) public health nursing;

(ii) social work;

(iii) nutrition;

(iv) primary care providers;

(v) subspecialty providers;

(vi) dental providers;

(vii) Part H early intervention providers;

(viii) paraprofessional home visitor program; and

(ix) others deemed appropriate by the contractor.

(3) Requirements for professional public health providers include:

(a) for a registered nurse: a minimum of a bachelor’s degree in nursing including course work in public health; and

(b) for a social worker: a master's or bachelor's degree in behavioral sciences or related field with one year experience in community social services or public health.

(4) The case management provider must be able to directly provide services of at least one of the professional disciplines listed in (3) of this rule.

(5) A case management provider must:

(a) deliver care coordination services appropriate to the child and caregiver's level of need;

(b) respond promptly to requests and referrals of children for targeted case management;

(c) perform assessments and develop care plans for the appropriate level of care and document the services provided;

(d) schedule services to accommodate the child's situation;

(e) inform a child and the child's caregivers regarding whom and when to call for health care emergencies;

(f) assure ongoing communication and coordination of the child's care occurs within the case management team and among the child's care providers;

(g) provide services primarily in the home setting and additionally in office or clinic settings with telephone contacts as appropriate. Home visiting, particularly by the public health nurse, is an integral part of targeted case management for children with special health care needs. To accommodate unusual circumstances or the safety of home visitors, exceptions to home visiting as the primary location of service delivery may be allowed and should be documented in the child's case record;

(h) have a system for handling grievances; and

(i) maintain an adequate and confidential client record system. All services provided must be documented in this system.

(6) A case manager must have knowledge of:

(a) federal, state and local programs for children such as WIC, immunizations, perinatal health care, children's special health care needs, family planning, genetic services, hepatitis B screening, EPSDT, DDFESS, and other health care related programs in Montana;

(b) individual health care systems, plan development, and evaluation;

(c) community health care systems and resources; and

(d) nationally recognized early childhood health care and well child health supervision standards.

(7) A case manager must have the ability to:

(a) interpret medical findings;

(b) develop or participate in the development of an individual case management plan based on assessment of a child's health, nutritional and psychosocial status, and personal and community resources;

(c) inform a child and the child's caregivers regarding health conditions and implications of risk factors;

(d) foster the ability of a child's caregivers to assume responsibility for the child's health care;

(e) assist the child and the child's caregivers to establish linkages among service providers;

(f) coordinate access to multiple provider services to benefit the child and the child's caregivers; and

(g) evaluate a child and the child's caregivers success in obtaining appropriate medical care and other needed services. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1997 MAR p. 496, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481.)

Rules 07 through 09 reserved

37.86.3910 CASE MANAGEMENT SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS, REIMBURSEMENT (1) Case management services for children with special health care needs are reimbursed at the lower of the following:

(a) the provider's customary charge to the general public for the service; or

(b) $10.00 for each 15 minutes of service.

(2) No cost shall be allowable unless the department determines that it has been incurred and that it is reasonable and necessarily related to the provision of case management services. Profit is not an allowable cost. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1997 MAR p. 496, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 481.)

Subchapters 40 and 41 reserved

Subchapter 42

Freestanding Dialysis Clinics for
End Stage Renal Disease

37.86.4201 FREESTANDING DIALYSIS CLINICS FOR END STAGE RENAL DISEASE, DEFINITIONS (1) "Freestanding dialysis clinics (FDC)" are facilities licensed by the officially designated authority in the state where the institution is located and certified by the health care financing administration (HCFA) to:

(a) furnish outpatient maintenance dialysis directly to end stage renal disease (ESRD) patients; and

(b) provide training for self-dialysis and home dialysis. (History: Sec. 53-6-113, MCA, IMP, Sec. 53-6-101, MCA; NEW, 1990 MAR p. 1607, Eff. 8/17/90; TRANS, from SRS, 2000 MAR p. 481.)

37.86.4202 FREESTANDING DIALYSIS CLINICS FOR END STAGE RENAL DISEASE, REQUIREMENTS (1) These requirements are in addition to those contained in ARM 37.85.401, 37.85.402, 37.85.406, 37.85.407, 37.85.410, 37.85.414, 37.85.415 and 46.12.314.

(2) The provision of outpatient maintenance dialysis and related services by the medicaid program shall be coordinated with the medicare renal disease program as provided in Title XVIII of the Social Security Act and any other program providing the same or similar service.

(3) Outpatient maintenance dialysis and related services in a FDC shall be provided only to a person who has been diagnosed as suffering from chronic ESRD by a physician. (History: Sec. 53-6-113, MCA, IMP, Sec. 53-6-101, MCA; NEW, 1990 MAR p. 1607, Eff. 8/17/90; TRANS, from SRS, 2000 MAR p. 481.)

Rules 03 and 04 reserved

37.86.4205 FREESTANDING DIALYSIS CLINICS FOR END STAGE RENAL DISEASE, REIMBURSEMENT (1) Reimbursement for outpatient maintenance dialysis and other related services provided in a FDC shall be as follows:

(a) FDCs will be reimbursed under the composite rate reimbursement system for independent facilities in accordance with 42 CFR 413, subpart H and as detailed in the HIM-15, chapter 27. The department hereby adopts and incorporates by reference 42 CFR 413, subpart H (1989 edition) and the HIM-15, chapter 27 (1983 edition). Copies may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(b) The reimbursement period will be the FDC's fiscal year.

(c) These reimbursement rules are in addition to those contained in ARM 46.12.509(2) through (6). (History: Sec. 53-6-113, MCA, IMP, Sec. 53-6-101, MCA; NEW, 1990 MAR p. 1607, Eff. 8/17/90; TRANS, from SRS, 2000 MAR p. 481.)

Subchapter 43 reserved

Subchapter 44

Rural Health Clinics and Federally
Qualified Health Centers

37.86.4401 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, DEFINITIONS In this subchapter the following definitions apply:

(1) "Category of service" means a type of medicaid covered service that is furnished in an RHC or FQHC.

(2) "Crossover claim" means a claim for services provided to medicare/medicaid dual eligibles or qualified medicare beneficiaries.

(3) "Federally qualified health center (FQHC)" means an entity which is a federally qualified health center as defined in 42 USC 1396d(l)(2)(B) (2003 Supp.). For purposes of defining "federally qualified health center" the department adopts and incorporates by reference 42 USC 1396d(l)(2)(B) (2003 Supp.), which is a federal statute defining "federally qualified health center" for purposes of the medicaid program. A copy of the cited statute is available upon request from the Department of Public Health and Human Services, Health Resources Division, Hospital and Clinical Services Bureau 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(4) "FQHC core services" means the FQHC ambulatory services defined in 42 USC 1396d(l)(2)(A) and described in 42 USC 1395x(aa)(1). For purposes of defining and describing FQHC core services, the department adopts and incorporates by reference 42 USC 1396d(l)(2)(A) and 42 1395x(aa)(1) (2003 Supp.). The cited statutes are federal medicaid and medicare statutes defining certain FQHC services for purposes of the medicaid and medicare programs. Copies of the cited statutes are available upon request from the Department of Public Health and Human Services, Health Resources Division, Hospital and Clinical Services Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(5) "FQHC other ambulatory services" means ambulatory FQHC services, other than FQHC core services, that would be covered under the Montana medicaid program if provided by an individual or entity other than an FQHC in accordance with applicable medicaid requirements.

(6) "FQHC services" means FQHC core services and FQHC other ambulatory services.

(7) "Increase or decrease in the scope of service" means the addition or deletion of a service or a change in the magnitude, intensity or character of services provided by an FQHC or RHC or one of their sites. The increase or decrease in the scope of service must reasonably be expected to last at least one year. The term includes but is not limited to:

(a) an increase or decrease in intensity attributable to changes in the types of patients served, including but not limited to HIV/AIDS, the homeless, elderly, migrant or other chronic diseases or special populations;

(b) any changes in services or provider mix provided by an FQHC or RHC or one or their sites;

(c) increases or decreases in operating costs that have occurred during the fiscal year and that are attributable to capital expenditures, including new service facilities or regulatory compliance; and

(d) any approved changes in scope of project as defined by the health resources and service administration (HRSA).

(8) "Independent entity" means a rural health clinic or an FQHC that is not a provider-based entity.

(9) "Provider" means the entity enrolled in the Montana medicaid program as a provider of RHC or FQHC services.

(10) "Provider-based entity" means an FQHC or RHC that is an integral and subordinate part of a hospital, skilled nursing facility, or home health agency that is participating in the medicare program and that is operated with other departments of the provider under common licensure, governance and professional supervision.

(11) "Reporting period" means a period of 12 consecutive months specified by an RHC or FQHC as the period for which the entity must report its costs and utilization. The reporting period must correspond to the provider's fiscal year. The first and last reporting periods may be less than 12 months.

(12) "Rural health clinic (RHC)" means a clinic determined by the secretary of the United States department of health and human services to meet the rural health clinic conditions of certification specified in 42 CFR, part 491, subpart A.

(13) "RHC core services" means the rural health clinic services described in 42 CFR 440.20(b)(1) through (4).

(14) "RHC other ambulatory services" means other ambulatory services furnished by an RHC as described in 42 CFR 440.20(c).

(15) "Rural health clinic (RHC) services" means RHC core services and RHC other ambulatory services.

(16) "Visit" means a face-to-face encounter between a clinic or center patient and a clinic or center health professional for the purpose of providing RHC or FQHC core or other ambulatory services. For purposes of this subchapter, the terms of ARM 37.86.4402 must be used to determine whether an encounter or series of encounters is one or more visits. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1998 MAR p. 2045, Eff. 7/31/98; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 2043, Eff. 10/12/01; AMD, 2005 MAR p. 975, Eff. 6/17/05.)

37.86.4402 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, VISITS AND ENCOUNTERS (1) For purposes of this subchapter, a face-to-face encounter between a clinic or center patient and a clinic or center health professional for the purpose of providing RHC or FQHC core or other ambulatory services constitutes a single visit.

(2) Encounters that take place on the same day and at a single location constitute a single visit, although the encounters were:

(a) with more than one clinic or center health professional; or

(b) multiple encounters with the same clinic or center health professionals.

(3) Each additional encounter with clinic or center health professionals that takes place on the same day as a medical visit to the same clinic or center constitutes an additional visit if, after the first encounter:

(a) the patient suffers an additional illness or injury requiring additional diagnosis or treatment;

(b) the patient has a mental health visit consisting of one or more mental health encounters; or

(c) the patient has a dental visit consisting of one or more dental encounters. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 2005 MAR p. 975, Eff. 6/17/05.)

Rules 03 and 04 reserved

37.86.4405 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, PROVIDER PARTICIPATION REQUIREMENTS (1) The requirements of this subchapter are in addition to those contained in rule provisions generally applicable to medicaid providers.

(2) As a condition of participation in the Montana medicaid program, a RHC or FQHC must maintain a current Montana medicaid provider enrollment according to the requirements of ARM 37.85.402.

(3) As a condition of participation in the Montana medicaid program, a rural health clinic must be and remain certified by the medicare program under the conditions of certification specified in 42 CFR Part 491, subpart A.

(4) As a condition of participation in the Montana medicaid program, an FQHC must be a federally qualified health center as defined in 42 USC 1396d(l)(2)(B). (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1998 MAR p. 2045, Eff. 7/31/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 2043, Eff. 10/12/01.)

37.86.4406 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, SERVICE REQUIREMENTS (1) The Montana medicaid program will cover and reimburse under the RHC or FQHC programs only those services that are RHC services or FQHC services as defined in ARM 37.86.4401 and subject to the provisions of this subchapter.

(2) The Montana medicaid program will not reimburse an RHC or FQHC for RHC or FQHC services that are services covered by a health maintenance organization for an enrolled recipient, as provided in ARM Title 37, chapter 86, subchapter 50, except as provided in ARM 37.86.4414.

(3) RHC services are covered by Montana medicaid when provided in accordance with these rules to a recipient at the clinic, the recipient's residence or a hospital or other medical facility.

(4) FQHC services are covered by Montana medicaid when provided in accordance with these rules to a recipient in an outpatient setting only, which may include the recipient's place of residence. The recipient's place of residence may include a skilled nursing facility or a nursing facility. FQHC services are not covered by Montana medicaid when provided to a hospital patient.

(5) The Montana medicaid program will cover and reimburse RHC or FQHC services only if the services are provided in accordance with the same requirements that would apply if the service were provided by an individual or entity other than an RHC or an FQHC, except as specifically provided otherwise in this subchapter. These requirements include but are not limited to the following:

(a) The health professional providing the RHC or FQHC service must meet the same requirements that would apply if the health professional were to enroll directly in the Montana medicaid program in the category of service to be provided. Such requirements include but are not limited to applicable licensure, certification and registration requirements and applicable restrictions upon the form of entity or category of individual provider that may provide particular services. The health professional is not required to enroll separately as a medicaid provider.

(b) The RHC or FQHC services are subject to any applicable limitations on the amount, scope or duration of services covered by the medicaid program, e.g., scope of practice restrictions under state licensure law, coverage exclusions, e.g., non-coverage of physical therapy maintenance services, limits on the number of hours, visits or other units of service covered in a particular period or on the frequency of services covered, limits on the type of items or services covered within a particular category, medical necessity requirements, including specific medical necessity criteria applicable to a particular item or service, and early and periodic screening, diagnostic and treatment services (EPSDT) program requirements and restrictions.

(c) In addition to general record requirements under ARM 37.85.414, RHCs and FQHCs must comply with any additional particular record or documentation requirements applicable to the particular category or type of service, e.g., requirements for documentation of compliance with supervision and protocol requirements, requirements for written documentation of prescription or referral, requirements for written care plans and prerequisites for receipt of a particular item or service by a particular recipient.

(d) Providers must bill for RHC or FQHC services using the revenue codes specified in the department's RHC/FQHC services provider manual. The department must provide 30 days prior written notice to providers of any changes in revenue codes.

(e) RHCs and FQHCs must comply with requirements for medicaid program authorization prior to provision of services or prior to payment, as applicable to the particular category of services being provided.

(f) Reimbursement will be made to RHCs and FQHCs for RHC and FQHC services as provided in ARM 37.86.4412 through 37.86.4414 and 37.86.4420, rather than as provided in the rules applicable to the particular category of services. This rule shall not be construed to provide that reimbursement of services provided by health professionals will be made under ARM 37.86.4412 through 37.86.4414 and 37.86.4420 when the services are not provided as an RHC or FQHC service and when the health professional is separately enrolled in and providing services under a particular medicaid service category, subject to the rules applicable to the particular service category.

(6) A provider must notify the department, in writing, of an increase or decrease in the scope of service offered by the RHC or FQHC to medicaid recipients. Upon the request of a provider, the department will determine if a change qualifies as an increase or decrease in the scope of service, and if so, the amount and effective date of any rate increase or decrease.

(a) As a condition of approval, the department may require the provider to submit documentation and information necessary to demonstrate compliance with requirements applicable to the category of service and/or documentation and information necessary to determine the increase or decrease in the reimbursement rate due to an increase or decrease in the scope of service including any increase or decrease in the costs of the service and any increase or decrease in the number of visits.

(b) Medicaid coverage and reimbursement of an additional category of service will not be available to a provider unless department approval was requested prior to provision of the services and unless the services comply with all applicable requirements.

(c) Any increase in the rate of reimbursement due to an increase or decrease in the scope of service shall be from the date of notification by the provider to the department. Any decrease in the rate of reimbursement due to an increase or decrease in the scope of service shall be from the date the department was notified by the provider or the date the department determines the increase or decrease in the scope of services occurred, whichever is first.

(d) The department shall complete the determination within 60 days of the written request or within 60 days of receipt of any required documentation and information, whichever is later.

(7) If clinic or center services are provided in more than one location, each location is independently considered for approval as an RHC or FQHC medicaid provider, unless prior approval was granted by the department, to operate both locations under one provider number. To be considered for operation under one provider number, both sites must share medical staff, office staff or administrative staff. The provider must notify the department of this change in status as provided in (6). (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1998 MAR p. 2045, Eff. 7/31/98; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 2043, Eff. 10/12/01; AMD, 2005 MAR p. 975, Eff. 6/17/05.)

37.86.4407 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, RECORD KEEPING AND REPORTS (1) A provider must meet the record keeping and other requirements of ARM 37.85.414 in addition to the requirements of this rule.

(2) A provider must make and maintain adequate financial and statistical records in accordance with generally accepted accounting principles, as defined by the American institute of certified public accountants. The provider's records must be sufficient to allow the department and its agents to determine payment for the RHC or FQHC services provided to medicaid recipients and to provide a record that may be audited using generally accepted auditing standards. Such records must be maintained for a period of six years, three months after a cost report is filed with respect to the period covered by such records or until such cost report is finally settled, whichever is later.

(3) The records described in (2) must be available at the provider facility at all reasonable times and shall be subject to inspection, review and audit by the department or its agents, the United States department of health and human services, the general accounting office, the Montana legislative auditor, and other governmental agencies as authorized by law.

(4) Upon failure or refusal of the provider to make available and allow access to such records, or to report an increase or decrease in scope of services, the department may recover in full all payments made to the provider during the reporting period to which such records relate and may suspend any further payments to the provider until such time as the provider fully complies with this rule.

(5) No later than 30 days prior to the beginning of its initial reporting period as a new provider or following a change in ownership, a provider must submit to the department or its agent an estimate of budgeted costs and visits for RHC or FQHC services for the reporting period in the form and detail required by the department and such other information as the department may require to establish a rate as provided at ARM 37.86.4413. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1998 MAR p. 2045, Eff. 7/31/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 2043, Eff. 10/12/01; AMD, 2005 MAR p. 975, Eff. 6/17/05.)

Rules 08 through 11 reserved

37.86.4412 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, REIMBURSEMENT (1) This subchapter specifies requirements applicable to provision of and reimbursement for RHC and FQHC services. These rules are in addition to requirements generally applicable to medicaid providers as otherwise provided in state and federal statute, rules, regulations and policies.

(2) Unless otherwise provided in these rules, this subchapter applies to rate years beginning on or after January 1, 2001. Reimbursement and other substantive RHC and FQHC requirements for earlier periods are subject to the laws, regulations, rules and policies then in effect. Procedural and other non-substantive provisions of these rules are effective upon adoption.

(3) All RHCs and FQHCs will be reimbursed on a prospective payment system beginning January 1, 2001 and each succeeding calendar year. The prospective payment system will apply equally to provider based and independent RHCs and FQHCs.

(4) On January 1 of each succeeding calendar year, the rate for the preceding year must be adjusted by the percentage increase in the medicare economic index (MEI) applicable to primary care services for that calendar year.

(5) The department will reimburse the RHC or FQHC for the rate change in (4) retroactive to the effective date of January 1 of the calendar year, beginning with January 1, 2002.

(6) For clinics or centers that had their initial medicaid prospective system base visit rate calculated in 2001 or starting with the third fiscal year (for "new" clinics or centers as defined at ARM 37.86.4413), the prospective payment per visit rate may be adjusted to take into account any increase or decrease in the scope of service.

(a) The department will determine the new rate according to the following formula:

$$NR = \frac{(R \times PV) + C}{(PV + CV)}$$

(i) "NR" represents the new reimbursement rate adjusted for the increase or decrease in the scope of service;

(ii) "R" represents the present outpatient prospective payment system (OPPS) medicaid rate;

(iii) "PV" represents the present number of total visits which is the total number of visits for the RHC or FQHC during the 12-month time period prior to the change in scope of service;

(iv) "C" represents the expected change in costs due to the change in scope of service; and

(v) "CV" represents the expected change in the number of visits due to the change in scope of service. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1998 MAR p. 2045, Eff. 7/31/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 2043, Eff. 10/12/01; AMD, 2005 MAR p. 975, Eff. 6/17/05.)

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37.86.4413 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, ESTABLISHMENT OF INITIAL PAYMENT FOR NEW CLINICS OR CENTERS (1) To determine the initial medicaid prospective payment system base per visit rate for a newly qualified RHC or FQHC, reimbursement shall be equal to 100% of the average prospective payment system rates for other RHCs or FQHCs located in the same or adjacent area with a similar caseload. In the event that there is no such RHC or FQHC, payment shall be made in accordance with the methodology provided in (2) through (4).

(2) During the RHC's or FQHC's first two fiscal years, the RHC or FQHC will be reimbursed on a per visit basis equal to the RHC's or FQHC's total projected costs divided by the RHC's or FQHC's total projected visits. The provider must submit to the department or its agent an estimate of budgeted costs and visits for the RHC or FQHC for the reporting period in the form and detail required by the department and such other information as the department may require to establish a rate.

(3) At the end of the RHC's or FQHC's first two fiscal years, a new per visit rate shall be established that is equal to 100% of the allowable costs of the RHC or FQHC furnishing such services during the RHC's or FQHC's first two fiscal years which are reasonable and related to the cost of furnishing such services. The provider must submit to the department or its agent the costs and visits for the RHC or FQHC for the reporting period in the form and detail required by the department and such other information as the department may require to establish a rate.

(a) The formula for calculating this new base per visit rate is the total cost of core and other ambulatory services for the first two fiscal years divided by the total core and other ambulatory visits for the first two fiscal years. This base cost per visit rate may be adjusted to take into account any increase or decrease in the scope of service as provided in ARM 37.86.4412.

(b) The department shall reimburse the RHC or FQHC this new base rate retroactive to the effective date of their enrollment as an RHC or FQHC.

(4) Reimbursement for the third year forward shall be as in ARM 37.86.4406 and 37.86.4412. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1998 MAR p. 2045, Eff. 7/31/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2043, Eff. 10/12/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01; AMD, 2005 MAR p. 1402, Eff. 6/17/05.)

37.86.4414 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, SUPPLEMENTAL PAYMENTS IN CASE OF MANAGED CARE

(1) In the case of services furnished by an RHC or FQHC pursuant to a contract between the RHC or FQHC and a managed care entity (as defined in section 1932(a)(1)(B) and 1932(a)(1)(C) of the Social Security Act), payment to the RHC or FQHC shall be a supplemental payment equal to the amount (if any) by which the amount determined under medicaid prospective payment system exceeds the amount of the payments provided under the contract.

(2) The supplemental payment required shall be made quarterly. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1998 MAR p. 2045, Eff. 7/31/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 2043, Eff. 10/12/01.)

Rules 15 through 19 reserved

37.86.4420 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, ALTERNATIVE PAYMENT METHODOLOGIES (1) In the case of a catastrophic event or extraordinary circumstance that would directly impact the cost of medical services provided by an RHC or FQHC, or upon mutual agreement of the department and the RHC or FQHC the department may provide for payment in any year to an RHC or FQHC for services described in section 1905(a)(2)(B) and (C) of the Social Security Act in an amount determined under an alternative payment methodology that:

(a) is agreed to by the department and the RHC or FQHC; and

(b) results in payment to the RHC or FQHC of an amount which is at least equal to the amount otherwise required to be paid to the RHC or FQHC under the medicaid prospective payment system. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1998 MAR p. 2045, Eff. 7/31/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 2043, Eff. 10/12/01.)

Subchapters 45 and 46 reserved

Subchapter 47

Organ Transplant Services

37.86.4701 ORGAN TRANSPLANTATION, DEFINITIONS (1) "Organ transplantation" means the implantation of a living (viable) functioning human organ or organ system including bone marrow for the purpose of maintaining all or a major part of that organ function in the recipient.

(2) Organ transplantation includes the transplant surgery and those activities directly related to the transplantation. These activities must be performed at a transplant facility if required by medicare. These activities may include:

(a) evaluation of the patient as a potential transplant candidate;

(b) pre-transplant preparation including histo-compatibility testing procedures;

(c) post surgical hospitalization;

(d) outpatient care, including federal drug administration (FDA) approved medications deemed necessary for maintenance or because of resulting complications.

(3) "Transplant facility" means a medical facility which:

(a) has received medicare certification as a transplant facility, unless medicare does not certify facilities to perform transplants of a particular organ or system; and

(b) participates in the Montana medicaid program. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1987 MAR p. 907, Eff. 7/1/87; AMD, 1991 MAR p. 2049, Eff. 11/1/91; AMD, 1993 MAR p. 1367, Eff. 6/25/93; TRANS, from SRS, 2000 MAR p. 481.)

Rules 02 through 04 reserved

37.86.4705 ORGAN TRANSPLANTATION, REQUIREMENTS (1) This rule provides the requirements for medicaid coverage of organ transplantations. The requirements in this rule are in addition to those contained in ARM 37.85.401, 37.85.402, 37.85.406, 37.85.407, 37.85.410, 37.85.414 and 37.85.415.

(2) General requirements for medicaid coverage of transplantations are as follows:

(a) The transplantation must be medically necessary.

(b) Prior authorization for referral to an out-of-state facility for an evaluation and organ transplantation must be obtained from the department or its designated review organization.

(c) The transplant candidate must meet the patient selection criteria set forth by the department's designated review organization.

(d) The medicaid program covers only the following organ transplantation services for persons over the age of 21, subject to the provisions of (2)(e):

(i) allogenic and autologous bone marrow;

(ii) kidney, inclusive of thoracic duct drainage and dental exam;

(iii) cornea;

(iv) lymphocyte immune globulin preparation.

(e) For purposes of establishing organ transplant requirements and to more specifically defining coverage or non-coverage of various types of organ transplantations, the department hereby adopts and incorporates by reference the following sections of the Medicare Coverage Issues Manual (HCFA-Pub. 6) published by the health care financing administration of the United States department of health and human services. A copy of the incorporated sections of the Medicare Coverage Issues Manual (HCFA-Pub. 6) may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. The incorporated sections are as follows:

(i) HCFA-Pub. 6, section 35-30, as amended through March 1992, pertaining to allogenic and autologous bone marrow transplantation;

(ii) HCFA-Pub. 6, section 35-50, as amended through September 1991, pertaining to non-coverage of the medical procedure cochleostomy with neurovascular transplant for treatment of meniere's disease;

(iii) HCFA-Pub 6, section 35-53.1, as amended September 1991, pertaining to pediatric liver transplantation;

(iv) HCFA-Pub. 6, section 35-58, as amended through April 1983, pertaining to thoracic duct drainage (TDD) as a covered service when furnished to a kidney transplant recipient or individual approved to receive a transplant;

(v) HCFA-Pub. 6, section 35-82, as amended through January 1988, pertaining to non-coverage of pancreas transplantation;

(vi) HCFA-Pub. 6, section 35-87, as amended through May 1989, pertaining to heart transplants;

(vii) HCFA-Pub. 6, section 45-22, as amended through June 1988, pertaining to FDA approval and use of lymphocyte immune globulin preparations;

(viii) HCFA-Pub. 6, section 50-23, as amended through July 1990, pertaining to the safe and effective use of histocompatibility testing procedures; and

(ix) HCFA-Pub. 6, section 50-26, as amended through May 1989, pertaining to dental exam as part of a comprehensive workup prior to a renal transplant surgery.

(3) The medicaid program covers organ transplantation services for persons 21 years of age or less as determined medically necessary, subject to the provisions of ARM 37.86.4701 and (2)(a) through (2)(e) of this rule. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-113, 53-6-131 and 53-6-141, MCA; NEW, 1987 MAR p. 907, Eff. 7/1/87; AMD, 1991 MAR p. 2049, Eff. 11/1/91; AMD, 1993 MAR p. 1367, Eff. 6/25/93; TRANS, from SRS, 2000 MAR p. 481.)

37.86.4706 ORGAN TRANSPLANTATION, REIMBURSEMENT

(1) Reimbursement for physician services in organ transplantation is provided in accordance with the methodologies described in ARM 37.85.212 and 37.86.105.

(2) All hospital services for organ transplantation are reimbursed as provided for in ARM 46.12.509. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-131 and 53-6-141, MCA; NEW, 1987 MAR p. 907, Eff. 7/1/87; AMD, 1998 MAR p. 676, Eff. 3/13/98; TRANS, from SRS, 2000 MAR p. 481.)

Subchapters 48 and 49 reserved

Subchapter 50

Health Maintenance Organizations (HMO)

37.86.5001 HEALTH MAINTENANCE ORGANIZATIONS: DEFINITIONS

(1) "Administrative contractor for managed care" means the entity the department contracts with to perform certain administrative functions of the managed health care programs.

(2) "Basic medicaid" means the program of medicaid services for adults receiving medical assistance through the FAIM program who are 21 years and older and not pregnant. Basic medicaid excludes coverage for dental services, most durable medical equipment and supplies, eye examinations, eyeglasses, hearing aids, audiology services, and personal care services.

(3) "Capitation rate" means the fee the department pays monthly to an HMO for the provision of covered medical and health services to each enrolled recipient. The fee is reimbursed whether or not the enrolled recipient received services during the month for which the fee is intended. The fee may vary by age, eligibility category and region.

(4) "Community-based organizations" means local governmental and nonprofit organizations providing programs of preventive and other health related services. Community-based organizations include but are not limited to: local family planning services; local women, infants and children (WIC) projects; local projects of Montana initiative for the abatement of mortality of infants (MIAMI); HIV testing, partner notification and early intervention; childhood lead poisoning prevention services; cherish our Indian children; follow me programs for special needs children.

(5) "Complaint" means an informal, verbal communication which an enrollee or their authorized representative presents regarding what the enrollee or their authorized representative perceives to be an inappropriate or lack of appropriate action by the HMO or any of its providers.

(6) "Contract" means a contract between the department and an HMO for the provision of medical and health services to medicaid recipients.

(7) "County office" means the location people go to apply for medicaid benefits that is either the department's local office of human services or the human services or welfare office of a county.

(8) "Covered services" means all or a part of the medical and health services set forth in ARM 37.86.5007 that an HMO is responsible for delivering to enrolled recipients under a contract with the department.

(9) "Day" means calendar days, except where the term working days or business days is expressly used.

(10) "Department" means the Montana department of public health and human services.

(11) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part.

(12) "Emergency room screens" means a medical screening examination within the capacity of the hospital's emergency department, including stabilization when necessary, to determine whether an emergency medical condition exists.

(13) "Emergency services" means, as defined at ARM 37.82.102, inpatient and outpatient hospital services that are necessary to treat an emergency medical condition.

(14) "Enrollee" means a medicaid recipient who has been certified by the department as eligible to enroll with an HMO, and whose name appears on the HMO's enrollment information that the administrative contractor for managed care transmits to the HMO every month as specified in the contract.

(15) "Enrollment area" means the county or counties that an HMO's certificate of authority from the state of Montana permits it to serve and in which the HMO has service capability as required by the department and set forth in the contract. If a proposed enrollment area is other than an entire county or counties, the proposed enrollment area should correspond to the normal service delivery area.

(16) "Exempt" means medicaid recipients who are not ineligible for managed care and who can prove it would be a hardship to participate in a managed care program. The department has the discretion to determine hardship and to place time limits on all exemptions on a case by case basis.

(17) "Families achieving independence in Montana (FAIM)" is a comprehensive welfare reform package. Participation in FAIM affects medicaid coverage for able-bodied adults 21 years and older. FAIM participants who are 21 years and older and not pregnant:

(a) are only eligible for basic medicaid;

(b) are required to enroll in an HMO if one is available in their area. If there is no HMO available, they must enroll in the passport to health program. If there is neither a passport to health program nor an HMO available, recipients stay on regular fee-for-service medicaid.

(18) "Federally qualified HMO" means an HMO qualified under section 1315(a) of the Public Health Service Act as determined by the U.S. public health service.

(19) "Full medicaid" means the full scope of medicaid benefits as defined in ARM 37.85.206.

(20) "Grievance" means a formal, written communication which an enrollee or their authorized representative presents regarding what the enrollee or their authorized representative perceives to be an inappropriate action or lack of appropriate action by the HMO or its providers.

(21) "Health maintenance organization (HMO)" means a health maintenance organization or its parent corporation with a certificate of authority issued in accordance with 33-31-201, et seq., MCA.

(22) "Ineligible" means medicaid recipients who are not allowed by the department to be under managed care and who must stay on regular medicaid. The following categories of recipients are ineligible:

(a) recipients with a spend down (medically needy);

(b) recipients living in a nursing home or institutional setting;

(c) recipients receiving medicaid for less than 3 months;

(d) recipients on the medicaid restricted card program;

(e) recipients who have medicare;

(f) recipients who live in an area without medicaid managed care;

(g) recipients in the medicaid eligibility subgroup of subsidized adoption;

(h) recipients whose eligibility period is only retroactive;

(i) recipients who cannot find a primary care provider who is willing to provide case management;

(j) recipients who are receiving medicaid home and community services for persons who are aged or disabled; and

(k) recipients who reside in a county in which there are not enough primary care providers to serve the medicaid population required to participate in the program.

(23) "Managed health care provider" means any one of the alternative systems for delivery of regular fee-for-service medicaid services. Managed health care provider includes health maintenance organizations (HMOs) and primary care case management programs.

(24) "Participating provider" means any person or entity that has entered into a contract with an HMO to provide medical care.

(25) "Primary care provider" means a physician, clinic, or mid-level practitioner other than a certified registered nurse anesthetist that is responsible by contract to serve an HMO's enrollees that has been designated by an enrollee as the provider through whom the enrollee obtains health care benefits provided by the HMO. A primary care provider attends to an enrollee's routine medical care, supervises and coordinates all of the enrollee's health care, determines the need for and initiates all referrals, determines the provider of medical services and determines the medical necessity of the medical services to be performed. Obstetrician or gynecologist means a physician who is board eligible or board certified by the American board of obstetrics and gynecology.

(26) "Recipient" means a person who is eligible for medicaid in accordance with the legal authorities governing eligibility.

(27) "Regular medicaid" means the program of medicaid services for medicaid recipients that would have been available to an enrollee if the enrollee were not enrolled in an HMO.

(28) "Routine care" means medical care for a condition that is not likely to substantially worsen in the absence of immediate medical intervention and is not an urgent condition or an emergency. Routine care can be provided through regularly scheduled appointments without risk of permanent damage to the person's health status.

(29) "School based provider" means a provider that provides services in a school setting.

(30) "Upper payment limit" means the cost to the department of providing the same services to an actuarially equivalent non-enrolled population.

(31) "Urgent care" means medical care necessary for a condition that is not life threatening but which requires treatment that cannot wait for a regularly scheduled clinical appointment because of the prospect of the condition worsening without timely medical intervention.

(32) "Usual manner" means obtaining medicaid benefits in the manner that medicaid recipients obtain them through the regular medicaid program. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA; NEW, 1995 MAR p. 1974, Eff. 9/29/95; AMD, 1997 MAR p. 1210, Eff. 7/8/97; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00.)

37.86.5002 HEALTH MAINTENANCE ORGANIZATIONS: RECIPIENT ELIGIBILITY (1) A recipient in any one of the following categories is eligible to enroll with an HMO contracting with the department:

(a) a FAIM or family-related recipient required by ARM 37.86.5103 to participate in a primary care case management program; or

(b) an SSI recipient or SSI-related recipient required by ARM 37.86.5103 to participate in a primary care case management program.

(2) A recipient who is ineligible to participate in a primary care case management program is not eligible to enroll with an HMO contracting with the department. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-113, 53-6-116 and 53-6-117, MCA; NEW, 1995 MAR p. 1974, Eff. 9/29/95; AMD, 1997 MAR p. 503, Eff. 3/11/97; AMD, 1997 MAR p. 1210, Eff. 7/8/97; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00.)

Rules 03 and 04 reserved

37.86.5005 HEALTH MAINTENANCE ORGANIZATIONS: ENROLLMENT

(1) Recipient enrollment with an HMO contracting with the department is voluntary, except as noted below.

(a) Individuals 21 years of age or older receiving medicaid or medically needy assistance as participants of the FAIM project, and who are not pregnant, are required to enroll in an HMO if one is available in the enrollment area and has not reached its maximum enrollment. If the HMOs in the enrollment area are at maximum enrollment, the individual must participate in the passport to health program as required in ARM 37.86.5101, et seq.

(2) An eligible recipient may request enrollment with a particular HMO.

(3) An eligible recipient may only enroll with an HMO contracting with the department to provide HMO services in the locality of the recipient's residence.

(4) An eligible recipient who is hospitalized, other than a newborn recipient, may enroll initially with an HMO contracting with the department only after the recipient's discharge from the hospital.

(5) Enrollment is requested either by completing a form designated by the administrative contractor for managed care or by a written or verbal request to the administrative contractor for managed care.

(a) The form must be available through the county office, the HMO office, the administrative contractor for managed care, or other locations designated by the department.

(b) An HMO or any entity responsible for making the form available, receiving a form or a request, must forward the form or request in writing to the administrative contractor for managed care within 3 working days.

(6) An HMO must accept without restriction eligible recipients in the order in which they are received for enrollment by the administrative contractor for managed care until the HMO's maximum enrollment under the contract is reached.

(7) The effective date of enrollment for an eligible recipient must be no later than the first day of the second month subsequent to the date on which the administrative contractor for managed care receives the designated managed health care choice form or written or verbal request. The effective date must be earlier than the second subsequent month if enrollment can be processed before the last 4 working days of the month.

(8) An HMO may issue an appropriate identification card to an enrollee. A medicaid card is issued to enrollees by the department.

(9) Enrollment with an HMO is indicated by the appearance of the HMO's name and 24-hour telephone number on the medicaid card.

(10) An enrollee must obtain covered services as defined in ARM 37.86.5007 through the HMO.

(11) An enrollee may obtain noncovered services as defined in ARM 37.86.5007 in the usual manner. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-113, 53-6-116 and 53-6-117, MCA; NEW, 1995 MAR p. 1974, Eff. 9/29/95; AMD, 1996 MAR p. 284, Eff. 1/26/96; AMD, 1997 MAR p. 503, Eff. 3/11/97; AMD, 1997 MAR p. 1210, Eff. 7/8/97; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00.)

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37.86.5006 HEALTH MAINTENANCE ORGANIZATIONS: DISENROLLMENT (1) An enrollee may request, without good cause, disenrollment from an HMO at any time, except that an individual required to enroll in an HMO per ARM 37.86.5005(1)(a) may disenroll only for good cause as defined in (11) of this rule. (2) A disenrollment request must be accompanied by a choice for another managed health care provider.

(3) Disenrollment is requested by either completing a form designated by the administrative contractor for managed care or by a written or oral request to the administrative contractor for managed care.

(a) The form must be available through the same locations as specified in ARM 37.86.5005 for the enrollment form.

(b) An HMO or any other entity responsible for making the form available upon receiving a form or a request, must forward the form or request to the administrative contractor for managed care within 3 working days.

(4) An HMO, based on good cause, may request that the department disenroll a recipient. The request with the basis for the request must be in writing.

(a) Good cause does not include an adverse change in health status.

(b) An enrollee may be terminated from medical assistance for good cause if the enrollee:

(i) has committed acts of physical or verbal abuse that pose a threat to providers or other enrollees of the HMO;

(ii) has allowed a non-enrollee to use the HMO certification card to obtain services or has knowingly provided fraudulent information in applying for coverage;

(iii) has violated rules of the HMO stated in the evidence of coverage;

(iv) has violated rules adopted by the commissioner of insurance for enrollment in an HMO; or

(v) is unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for the enrollee's care. Disenrollment of an enrollee for this reason must be permitted only if the HMO can demonstrate that it provided the enrollee with the opportunity to select an alternate primary care physician, made a reasonable effort to assist the enrollee in establishing a satisfactory physician-patient relationship, and informed the enrollee that the enrollee may file a grievance on this matter.

(5) Disenrollment takes effect, at the earliest, the first day of the month after the month in which the administrative contractor for managed care receives the request for disenrollment, but no later than the first day of the second calendar month after the month in which the administrative contractor for managed care receives a request for disenrollment. The enrollee remains enrolled with the HMO and the HMO is responsible for services covered under the contract until the effective date of disenrollment which is always the first day of a month.

(6) The department will disenroll an enrollee from a particular HMO if:

(a) the contract between the department and the HMO is terminated; or

(b) the enrollee permanently moves outside the HMO's enrollment area.

(7) The department will disenroll an enrollee from an HMO if:

(a) the enrollee enters a medicaid eligibility group excluded from HMO enrollment; or

(b) the enrollee becomes ineligible for medicaid; or

(c) the enrollee moves outside the HMO's enrollment area.

(8) If an enrollee becomes ineligible for medicaid and is reinstated into medicaid within 1 month, the enrollee may be reenrolled with the same HMO.

(9) A recipient disenrolling or disenrolled from an HMO who remains medicaid eligible is eligible for regular medicaid.

(10) A person participating in the FAIM project who is required to enroll in an HMO under ARM 37.86.5005 is considered to have good cause to disenroll if the person:

(a) has a terminal illness;

(b) meets one of the conditions for exemption from or is ineligible for the passport to health program as defined in ARM 37.86.5103; or

(c) is under treatment by a physician or mid-level practitioner who is not affiliated with a medicaid HMO and the patient, provider, and department believe that a disruption of the patient/provider relationship may adversely affect treatment or cause unnecessary hardship to the patient. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-113, 53-6-116 and 53-6-117, MCA; NEW, 1995 MAR p. 2155, Eff. 9/29/95; AMD, 1996 MAR p. 284, Eff. 1/26/96; AMD, 1997 MAR p. 503, Eff. 3/11/97; AMD, 1997 MAR p. 1210, Eff. 7/8/97; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00.)

37.86.5007 HEALTH MAINTENANCE ORGANIZATIONS: COVERED SERVICES (1) An HMO must provide the following services:

(a) inpatient hospital services as defined at ARM 37.86.2901 and 37.86.2902;

(b) outpatient hospital services as defined at ARM 37.86.3001 and 37.86.3002;

(c) physician services as defined at ARM 37.86.101 and 37.86.104;

(d) family planning services as defined at ARM 37.86.1701 and 37.86.1705;

(e) home health services as defined at ARM 37.40.701 and 37.40.702;

(f) early periodic screening, diagnosis and treatment services for individuals under the age of 21 (EPSDT) as defined at ARM 37.86.1401, 37.86.1402, 37.86.2201, 37.86.2205 and 37.86.2206;

(g) non-hospital laboratory and x-ray services as defined at ARM 37.86.911;

(h) rural health clinic services as defined at ARM 37.86.4001;

(i) ambulance services as defined at ARM 37.86.2601 and 37.86.2602;

(j) ambulatory surgical center services as defined at ARM 37.86.1401, 37.86.1402 and 37.86.1405;

(k) chiropractor services as defined at ARM 37.86.2206(2)(b);

(l) diagnostic clinic services as defined at ARM 37.86.1401 and 37.86.1402;

(m) nutrition services as defined at ARM 37.86.2206(2)(a);

(n) federally qualified health center services as defined at ARM 37.86.4401;

(o) hospice services as defined at ARM 37.40.801 and 37.40.806;

(p) mid-level practitioner services as defined at ARM 37.86.201 and 37.86.202;

(q) immunizations recommended by the advisory committee on immunization practices;

(r) occupational therapy services as defined at ARM 37.86.601;

(s) physical therapy services as defined at ARM 37.86.601;

(t) podiatry services as defined at ARM 37.86.501 and 37.86.505;

(u) private duty nursing services as defined at ARM 37.86.2206(2)(f);

(v) county public health clinic services as defined at ARM 37.86.1401 and 37.86.1402;

(w) respiratory therapy services as defined at ARM 37.86.2206(2)(d);

(x) immunizations and well child screens provided by school based providers;

(y) speech therapy services as defined at ARM 37.86.601;

(z) targeted case management services for high risk pregnant women as defined at ARM 37.86.3301, 37.86.3305, 37.86.3006, 37.86.3401, 37.86.3402 and 37.86.3405; and

(aa) transplant services as defined at ARM 37.86.4701 and 37.86.4705.

(ab) prescription drugs supplied by a participating provider or a provider with a family planning and/or public health clinic;

(ac) durable medical equipment limited to diabetic supplies, oxygen, prosthetics, ostomy or incontinence supplies and only if supplied by a participating provider or a provider with a family planning and/or public health clinic;

(ad) optometric/ophthalmic services for medical conditions of the eye.

(2) An enrolled recipient may obtain the following covered services through self-referral to a participating or nonparticipating provider and the HMO must reimburse the provider of a service to which the enrollee may self-refer:

(a) family planning services:

(i) for enrollees with reproductive capacity, reproductive health exams comprised of taking history and conducting a physical assessment when such an exam is necessary to obtain birth control supplies or to determine the most appropriate birth control method or supply;

(ii) patient counseling and education for the following: contraception, sexuality, infertility, pregnancy, preconceptual care, pregnancy options, disease, HIV/AIDS, sterilizations, nutrition to maximize reproductive health, the need for rubella and hepatitis B immunizations, and other topics related to the patient's reproductive and general health;

(iii) lab tests to detect the presence of conditions affecting reproductive health, such as those involving the thyroid, cholesterol/triglycerides, prolactin, pregnancy tests, and diagnosis of infertility;

(iv) sterilizations as defined at ARM 37.86.104;

(v) screening, testing, and treatment of and pre- and post-test counseling for sexually transmitted diseases and HIV;

(vi) family planning supplies provided by Title X clinics; and

(vii) rubella and hepatitis B immunizations.

(b) immunizations provided by a public health clinic;

(c) blood lead level testing provided by a public health clinic; or

(d) emergency service.

(3) If a nonparticipating provider detects a problem outside the scope of family planning services as defined above, such provider shall refer the enrollee back to the HMO.

(4) An enrollee is eligible for all non-covered services and may obtain non-covered services in the usual manner. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA; NEW, 1995 MAR p. 2155, Eff. 9/29/95; AMD, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1997 MAR p. 1210, Eff. 7/8/97; AMD, 1997 MAR p. 1269, Eff. 7/22/97; AMD, 1998 MAR p. 2045, Eff. 7/31/98; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00.)

Rules 08 and 09 reserved

37.86.5010 HEALTH MAINTENANCE ORGANIZATIONS: CONTRACTS FOR SERVICES (1) The department may enter into a contract with an HMO with a certificate of authority under the provisions of 33-31-201, et seq., MCA, to provide any of the services specified in ARM 37.86.5007.

(2) An HMO, entering into a contract with the department, must meet the requirements in 53-6-705, MCA.

(3) A contract for the provision of services through an HMO must meet the requirements of 42 CFR part 434. The department hereby adopts and incorporates by reference 42 CFR part 434, dated October 1998. A copy of the incorporated provisions may be obtained through the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(4) An HMO entering into a contract with the department for the delivery of services assumes the risk that the costs of performance may exceed the consideration available through the capitation rate and otherwise.

(5) An HMO must provide the department with documented assurances to show that the HMO is not likely to become insolvent. This requirement may be satisfied by documenting compliance with 33-31-216, MCA.

(6) An HMO may not in any manner hold an enrollee responsible for the debts of the HMO.

(7) A contract with an HMO must:

(a) list the covered services to be provided by the HMO;

(b) specify the method and rate of reimbursement; and

(c) provide for disclosure of ownership and subcontractor relationship; and

(d) owners, directors, officers, or partners of the HMO must certify that they meet federal nondebarment requirements.

(8) A contract may be terminated for cause, if the contractor fails to:

(a) perform the services within the time limits specified in the contract;

(b) perform any requirement of the contract;

(c) perform its contractual duties or responsibilities specified in the standards of contractor performance defined in the contract;

(d) comply with any law, regulation or licensure and certification requirement; or

(e) comply with the restrictions and limitations placed on contractor activities under the contract and its attachments.

(9) Prior to termination of a contract or withholding of payments for cause, except as provided in (9)(a), a notice to cure will be sent to the HMO, stating the failures in performance and specifying the HMO has 30 days to correct the failures. The department may proceed with the proposed termination or withholding of payments, if the HMO fails to correct the failures in performance in the specified time period for correction.

(a) A contract with an HMO may be terminated immediately in whole or in part by the department when:

(i) the HMO becomes insolvent;

(ii) the HMO loses a certificate of authority;

(iii) the department determines that termination is necessary to protect the health of enrollees;

(iv) the HMO applies for or consents to the appointment of a receiver, trustee, or liquidation for itself or any of its property;

(v) the HMO admits in writing that it is unable to pay its debts as they mature;

(vi) the HMO assigns for the benefit of creditors;

(vii) the HMO commences a proceeding in bankruptcy, reorganization, insolvency, or readjustment under a provision of a federal or state law or files an answer admitting the material allegations of a petition filed against the contract in any such proceeding; or

(viii) there is a commencement of an involuntary proceeding against the HMO under any bankruptcy, reorganization, insolvency, or readjustment in a provision of federal or state law that is not dismissed within 60 days.

(10) An HMO may not appeal a contractual matter through the fair hearing process provided at ARM 46.2.201, et seq.

(11) An HMO may specify in a contract a limit to the number of enrollees who can be enrolled with the HMO. If a limit is specified, the HMO must accept the number of voluntarily and assigned enrollees up to the limit specified in the contract.

(12) The department may contract with one or more HMO or other managed health care providers to provide managed health care in an enrollment area.

(13) The contract may contain proprietary information. An HMO entering into a contract with the department to provide HMO covered services does not constitute an agreement to release information, including information concerning the provider's information system, which is proprietary in nature. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA; NEW, 1995 MAR p. 2155, Eff. 9/29/95; AMD, 1997 MAR p. 503, Eff. 3/11/97; AMD, 1997 MAR p. 1210, Eff. 7/8/97; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00.)

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37.86.5011 HEALTH MAINTENANCE ORGANIZATIONS: PROVISION OF SERVICES (1) An HMO may impose the following requirements in the provision of services:

(a) the use of certain types of providers;

(b) the preauthorization for services and use of network providers other than emergency services, family planning, immunizations and blood lead testing at a public health clinic;

(c) the use of network providers, on a self-referral basis, for obstetrical, gynecological, and maternity services;

(d) directing an enrollee to the appropriate level of care for receipt of covered services; and

(e) denial of payment to a provider for services provided to an enrollee if the participation requirements in this rule are not met by the enrollee; or

(f) if a recipient is mandated into an HMO and chooses to go to an FQHC that is not on the provider panel, approval for services is not required, but the recipient must inform the HMO before receiving services.

(2) An enrollee must use the participating providers in the enrollee's HMO.

(3) An enrolled recipient may use a nonparticipating provider in the following circumstances:

(a) the HMO authorizes a nonparticipating provider to provide a service;

(b) the enrollee receives a family planning service provided by a family planning provider as specified in ARM 37.86.5007(3);

(c) the enrollee receives an immunization or blood lead level testing provided by a public health clinic; or

(d) the enrollee receives services provided for an urgent condition or emergency or emergency room screen.

(4) An HMO must provide covered services as listed in ARM 37.86.5007 to enrollees in the same manner as those services are provided to non-medicaid enrollees.

(5) An HMO must make a reasonable effort to inform enrollees of alternate providers for noncovered services.

(6) An HMO, at a minimum, must provide enrollees the same amount, scope and duration for covered services as would be available under regular medicaid for those covered services.

(7) An HMO may at its discretion offer services to enrollees beyond the scope of medicaid as defined in ARM 37.85.206.

(8) An HMO must ensure that services for urgent conditions and emergencies are available on an immediate basis 24 hours a day, 7 days a week.

(a) An HMO may require that follow-up treatment to an urgent condition or emergency be provided by HMO participating providers. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA; NEW, 1995 MAR p. 1974, Eff. 9/29/95; AMD, 1997 MAR p. 1210, Eff. 7/8/97; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00.)

37.86.5012 HEALTH MAINTENANCE ORGANIZATIONS: PARTICIPATING PROVIDERS (1) An HMO, except as otherwise provided in this rule, may select the providers of medical services the HMO determines necessary to meet its contractual obligations with the department.

(2) The HMO must offer to:

(a) medicaid-enrolled targeted case managers for high risk pregnant women who serve recipients in the enrollment area, terms and conditions that are at least as favorable as those offered to other participating providers providing this service and that substantially meet the same access and credentialing criteria as like participating providers; and

(b) federally qualified health centers or rural health clinics which serve recipients in the enrollment area, terms and conditions, excluding reimbursement, that are at least as favorable as those offered to other primary care providers, providing the FQHC or RHC substantially meets the same access and credentialing criteria as the HMO's other primary care providers.

(3) An HMO must make a reasonable effort to cooperate, where appropriate and feasible, with community-based organizations in the referral for and delivery of services available through those organizations.

(4) An HMO may not contract for a service from a provider located over 125 miles distant from the Montana border if services of comparable cost and quality are available from a provider located within Montana.

(5) Upon written notice by the department, the HMO must exclude from providing covered services to medicaid enrollees a provider who has been terminated by the medicaid program in accordance with ARM 37.85.501(1)(a).

(6) An HMO may set notification and claim filing time limitations relating to the provision of care by nonparticipating providers. Failure to give notice or file claims within those time limitations, however, does not invalidate any claim if it can be shown not to have been reasonably possible to give such notice and that notice was in fact given as soon as was reasonably possible.

(7) A participating provider has no right to an administrative hearing as provided in ARM 37.5.101 and 37.5.117 or other department rule for a denial of payment by the HMO to the provider for a service provided to an enrollee.

(8) A participating provider, in providing services under contract with an HMO, is not subject to any requirements or rights provided in ARM 37.85.402(1), pertaining to medicaid provider enrollment, ARM 37.85.406 pertaining to medicaid billing and, ARM 37.85.411, pertaining to provider rights.

(9) An HMO must permit obstetricians/gynecologists to become primary care providers. An obstetrician or gynecologist seeking designation as a primary care provider must meet the same criteria with regard to credentials and other selection criteria for a participating primary care physician and other providers who are participating as primary care providers.

(10) An HMO may not prohibit a participating provider from discussing a treatment option with an enrollee or from advocating on behalf of an enrollee within the utilization review or grievance processes established by the HMO. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA; NEW, 1995 MAR p. 1974, Eff. 9/29/95; AMD, 1997 MAR p. 1210, Eff. 7/8/97; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

37.86.5013 HEALTH MAINTENANCE ORGANIZATIONS: REIMBURSEMENT OF PROVIDERS (1) An HMO must reimburse a federally qualified health center or a rural health clinic which is a participating provider either the same payment per enrollee or service made to other primary care providers or the facility specific medicaid interim rate for each enrollee visit.

(2) An HMO need not reimburse, except as otherwise provided in this rule, claims for medically necessary services provided by non-participating providers if the same service is covered by the HMO under its contract with the department.

(3) An HMO must reimburse medically necessary family planning services as defined in ARM 37.86.5007(3) provided by a nonparticipating family planning provider to an enrollee who sought the services without referral.

(4) An HMO must reimburse immunizations and blood lead testing provided by a public health clinic to an enrollee.

(5) An HMO must reimburse nonparticipating providers for services for urgent conditions, emergencies or emergency room screenings provided to an enrollee.

(6) An HMO, owned, controlled or sponsored by or affiliated with a religious organization, must reimburse a covered service received by an enrollee that the HMO does not make available due to the service constituting a violation of the religious tenets of the organization, to which the HMO is related.

(7) An HMO is not responsible for reimbursement of the disproportionate share payments for inpatient hospital services provided to an enrollee.

(8) An HMO must reimburse services for an urgent condition, emergency or emergency room screens in an amount that is not less than the department's medicaid rates for those services. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA; NEW, 1995 MAR p. 2155, Eff. 9/29/95; AMD, 1997 MAR p. 503, Eff. 3/11/97; AMD, 1997 MAR p. 1210, Eff. 7/8/97; TRANS, from SRS, 2000 MAR p. 481.)

37.86.5014 HEALTH MAINTENANCE ORGANIZATIONS: REIMBURSEMENT OF HMOS (1) In consideration for all services rendered by an HMO under a contract with the department, the HMO will receive a payment each month for each enrollee. This payment is the capitation rate. Except as otherwise provided in this rule, the capitation rate represents the total obligation of the department with respect to the costs of medical care and services provided to each enrollee under the contract.

(a) The capitation rate must be actuarially determined.

(b) The capitation rate must be:

(i) based on medicaid fee-for-service expenses incurred in the provision of the HMO-covered services to a non-HMO population of similar characteristics during the base fiscal year; and

(ii) based on services that are reasonably available to the enrollees of the HMO.

(c) The capitation rate may not exceed the cost to the department of providing the same services to an actuarially equivalent nonenrolled population group.

(d) The capitation rate may be updated annually.

(e) The capitation rate does not include:

(i) any amounts for the recoupment of losses suffered by an HMO for risks assumed under the contract or any previous risk contract;

(ii) any disproportionate share payments;

(iii) any payments made by the department reflecting the difference between the amounts paid to participating federally qualified health centers and rural health clinics by the HMO and the reasonable cost of providing services to enrollees; and

(iv) any payments made as a result of reinsurance purchased by an HMO from the department.

(f) At a minimum, the capitation rate must be 5% less than the upper payment limit. The department may reduce the capitation rates under the conditions set forth in the contract if there is a funding shortfall.

(2) The HMO may retain any savings realized by the HMO from the expenditures for necessary health services by the enrolled population totaling less than the capitation rate paid by the department.

(3) The department reimburses to federally qualified health centers and rural health clinics that are participating providers the difference between the amounts paid to them by the HMO and the reasonable cost of providing services to enrolled recipients.

(a) The department recoups from federally qualified health centers and rural health clinics that are participating providers any excess between the amounts paid to them by the HMO and the reasonable cost of providing services to enrollees, unless the provider notifies both the HMO and the department in writing that it forfeits cost-based reimbursement for enrollees in favor of the reimbursement paid by the HMO.

(b) If an HMO becomes a subcontractor to a federally qualified health center or rural health clinic, the department is under no obligation to pay reasonable costs to the HMO. Only the federally qualified health center or rural health clinic itself remains eligible for reasonable cost settlement for federally qualified health center and rural health clinic services.

(4) The department reimburses disproportionate share payments for inpatient hospital services provided to enrollees.

(5) The department will recoup the TANF-based capitation payments made for a newborn enrollee retroactively determined SSI eligible within 4 months of life and instead pay the SSI-based capitation rate for each month of enrollment.

(6) The department reimburses an HMO for 80% of regular medicaid reimbursement for cost above the reinsurance threshold chosen by the HMO if an HMO chooses to purchase reinsurance from the department. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA; NEW, 1995 MAR p. 1974, Eff. 9/29/95; AMD, 1997 MAR p. 503, Eff. 3/11/97; AMD, 1997 MAR p. 1210, Eff. 7/8/97; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00.)

Rules 15 through 19 reserved

37.86.5020 HEALTH MAINTENANCE ORGANIZATIONS: ACCESS TO SERVICES (1) An enrollee must have the opportunity to choose a primary care provider to the extent possible and medically appropriate from any of the participating primary care providers in the enrollee's HMO. The HMO may assign an enrollee to a primary care provider when an enrollee fails to chose one after being notified to do so. The assignment must be appropriate to the enrollee's age, sex and residence. The HMO may limit an enrollee's ability to change primary care providers without cause.

(2) An HMO must have in effect the following arrangements which provide for adequate after hours call-in coverage by participating providers:

(a) An after hours call-in must include 24-hour-a-day phone coverage;

(b) If a medical provider is unavailable to answer the initial telephone call, there must be a written protocol specifying when the answering party must consult a medical provider;

(c) Calls requiring a medical decision must be forwarded to the on-call medical provider;

(d) A response to each call which requires a medical decision must be provided by the medical provider within 60 minutes. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA; NEW, 1995 MAR p. 1974, Eff. 9/29/95; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00.)

Rules 21 through 24 reserved

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37.86.5025 HEALTH MAINTENANCE ORGANIZATIONS: GRIEVANCE PROCEDURES (1) An enrollee has the right of appeal as provided at ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.

(2) An HMO must have a written procedure, approved in writing by the department prior to implementation, for resolution of grievances brought by enrollees either individually or as a class. Except as noted below, the HMO's grievance procedure must provide for resolution of a grievance within 45 days of receipt of the grievance. Resolution may be extended beyond 45 days only with the written approval of the department. In a situation requiring urgent care or emergency care, the department may require the HMO to expedite resolution.

(3) An enrollee must exhaust the HMO's grievance procedure before appeal of the matter may be made to the department under the provisions of ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.

(4) For purposes of ARM 37.5.307(1)(c), the 90 day appeal period starts on the day the enrollee files a grievance with the HMO. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA; NEW, 1995 MAR p. 1974, Eff. 9/29/95; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

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37.86.5026 HEALTH MAINTENANCE ORGANIZATIONS: RECORDS AND CONFIDENTIALITY (1) An HMO must comply with the provisions of ARM 37.86.414 regarding maintenance and retention of medical and fiscal records.

(2) An HMO must submit reports and maintain records as required in the contract with the department.

(3) An HMO must have in effect arrangements to provide for an adequate medical record-keeping system which includes a complete medical record for each enrollee in accordance with provisions set forth in the contract. The complete medical record may be maintained by an HMO's participating provider.

(4) HMOS, participating providers, and the department are subject to the disclosure requirements of Title 50, chapter 16, MCA, and 33-19-306, MCA. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA; NEW, 1995 MAR p. 1974, Eff. 9/29/95; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00.)

37.86.5027 HEALTH MAINTENANCE ORGANIZATIONS: RECIPIENT EDUCATION (1) An HMO must have written instructions for enrollees in the use of all services provided. The policy must include, but is not limited to, written information on service restrictions and limitations regarding appropriate use of the referral system, grievance procedure, after hours call-in system, provisions for emergency treatment, how the enrollee may obtain services that are the responsibility of the HMO under ARM 37.86.5007 and the contract between the HMO and the department but which are not available through the HMO due to religious objections and how to request a list of the HMO's participating providers. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA; NEW, 1995 MAR p. 1974, Eff. 9/29/95; AMD, 1997 MAR p. 1210, Eff. 7/8/97; TRANS, from SRS, 2000 MAR p. 481.)

Rules 28 through 34 reserved

37.86.5035 HEALTH MAINTENANCE ORGANIZATIONS: QUALITY ASSURANCE (1) An HMO must have in effect an internal quality assurance system as specified in the contract.

(2) An internal quality assurance system must meet the requirements of 42 CFR 434.34. The department hereby adopts and incorporates by reference 42 CFR 434.34, dated October 1998.

(a) Copies of 42 CFR 434.34 may be obtained through the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA; NEW, 1995 MAR p. 1974, Eff. 9/29/95; AMD, 1997 MAR p. 503, Eff. 3/11/97; AMD, 1997 MAR p. 1210, Eff. 7/8/97; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00.)

37.86.5036 HEALTH MAINTENANCE ORGANIZATIONS: THIRD PARTY (1) The HMO is responsible for investigating third party resources and seeking payment from these sources.

(2) The HMO may retain all funds collected from third party resources.

(3) A complete record of all payments received from third party sources must be maintained and reported as required in the contract. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA; NEW, 1995 MAR p. 2155, Eff. 9/29/95; TRANS, from SRS, 2000 MAR p. 481.)

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Subchapter 51

Passport to Health Program

37.86.5101 PASSPORT TO HEALTH PROGRAM: AUTHORITY

(1) The department has been granted by the United States department of health and human services (HHS), as provided in 42 U.S.C. 1396n(b), the authority to establish a primary care case management program for medicaid recipients. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-116, MCA; NEW, 1992 MAR p. 2288, Eff. 10/16/92; TRANS, from SRS, 2000 MAR p. 481.)

37.86.5102 PASSPORT TO HEALTH PROGRAM: DEFINITIONS

(1) "Authorization" means the approval by a primary care provider for the delivery to an enrollee by another provider of a service defined in ARM 37.86.5110. Authorization includes the provision of the primary care provider's medicaid number, unique physician identifying number (UPIN), or the provider's passport number to the other treating provider. The primary care provider shall establish parameters of the authorization.

(2) "Case management" means directing and overseeing the delivery of certain services to an enrollee.

(3) "Clinic" means a federally-qualified health center, a rural health clinic, an Indian health service clinic on a reservation, or any other clinic as defined in ARM 37.86.1401 which can meet the requirements of ARM 37.86.5111.

(4) "Emergency service" means, as defined at ARM 37.82.102(11), inpatient and outpatient services that are necessary to treat an emergency medical condition.

(5) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part.

(6) "Enroll" means to choose a primary care provider.

(7) "Enrollee" means a medicaid recipient participating in the program and who is enrolled with a primary care provider under the program.

(8) "Exempt" means medicaid recipients who are eligible for managed care but are able to establish it would be a hardship to participate in a managed care program. The department has the discretion to determine hardship and to place time limits on all exemptions on a case by case basis.

(9) "Ineligible" means a medicaid recipient who is not allowed to participate in a managed care program, such as the passport program, but is eligible for regular medicaid. The following categories of recipients are ineligible for the passport program:

(a) recipients with a spend down (medically needy) requirement;

(b) recipients living in a nursing home or institutional setting;

(c) recipients receiving medicaid for less than three months;

(d) recipients who have medicare;

(e) recipients who live in an area without medicaid managed care;

(f) recipients in the medicaid eligibility subgroup of subsidized adoption;

(g) recipients whose eligibility period is only retroactive;

(h) recipients who cannot find a primary care provider who is willing to provide case management;

(i) recipients who are receiving medicaid home and community services for persons who are aged or disabled; and

(j) recipients who reside in a county in which there are not enough primary care providers to serve the medicaid population required to participate in the program.

(10) "Medical care" means care provided to meet the medical and medically-related needs of a person.

(11) "Participate" means compliance with the requirements of the program.

(12) "Passport to health program" or "the program" means the primary care case management (PCCM) program for medicaid recipients.

(13) "Primary care" means medical care provided at a person's first point of contact with the health care system, except for emergencies. It includes treatment of illness and injury, health promotion and education, identification of persons at special risk, early detection of serious disease, promotion of preventive health care, and referral to specialists when appropriate.

(14) "Primary care case management" or "managed care" means promoting the access to, coordination of, quality of, and appropriate use of medical care, and containing the costs of medical care by having an enrollee obtain certain medical care from and through a primary care provider.

(15) "Team care" means a program for recipients identified as inappropriate utilizers of the medicaid program as set forth in ARM 37.86.5303. A medicaid recipient living in a nursing home or institutional setting and a recipient whose eligibility period is limited to a retroactive period only are ineligible for the team care program.

(16) "Primary care provider" means a physician, clinic, or mid-level practitioner other than a certified registered nurse anesthetist that is responsible by agreement with the department for providing primary care case management to enrollees in the passport to health program. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-113 and 53-6-116, MCA; NEW, 1992 MAR p. 2288, Eff. 10/16/92; AMD, 1994 MAR p. 313, Eff. 2/11/94; AMD, 1994 MAR p. 2983, Eff. 11/11/94; AMD, 1996 MAR p. 2193, Eff. 8/9/96; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00; AMD, 2004 MAR p. 1624, Eff. 7/23/04.)

37.86.5103 PASSPORT TO HEALTH PROGRAM: ELIGIBILITY

(1) The department may require a medicaid recipient in any of the following medicaid eligibility groups to enroll and participate in the passport to health program, unless exempted from or ineligible for participation as defined by ARM 37.86.5102(8) or (9):

(a) families achieving independence in Montana (FAIM);

(b) supplemental security income (SSI); or

(c) SSI-related.

(2) A medicaid recipient is exempt from or is not allowed to participate in passport to health if the recipient:

(a) is exempted by the department from participation because of hardship; or

(b) is enrolled in a health maintenance organization (HMO).

(3) A non-pregnant, medicaid recipient 21 years of age or older and eligible for medicaid as a participant in the TANF welfare demonstration project as required at ARM 37.78.101, et seq., must enroll in an HMO unless an HMO is not available or the available HMOs are at capacity.

(4) At the department's discretion, medicaid recipients who are exempted from participation, as defined in ARM 37.86.5102(8), may elect to enroll in a passport to health program by choosing a primary care provider from a county that the program serves, unless the recipient is ineligible. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-113, 53-6-116 and 53-6-117, MCA; NEW, 1992 MAR p. 2288, Eff. 10/16/92; AMD, 1994 MAR p. 2983, Eff. 11/11/94; AMD, 1996 MAR p. 284, Eff. 1/26/96; AMD, 1996 MAR p. 2193, Eff. 8/9/96; AMD, 1997 MAR p. 2085, Eff. 11/18/97; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00; AMD, 2004 MAR p. 1624, Eff. 7/23/04.)

37.86.5104 PASSPORT TO HEALTH PROGRAM: ENROLLMENT IN THE PROGRAM (1) The department will notify a medicaid recipient required by ARM 37.86.5103 to enroll in the program that the recipient must enroll in the program.

(2) The recipient required to enroll in the program must select a primary care provider within 45 days of being notified of the enrollment requirement. For team care program recipients, enrollment with a provider will be as required at ARM 37.86.5303.

(3) If the recipient does not choose a provider within 45 days of the notification, the department may designate a primary care provider for the recipient. For team care program recipients, enrollment with a provider will be as required in ARM 37.86.5303.

(4) An enrolling recipient must choose a primary care provider from the list of primary care providers.

(5) An enrollee may choose a new primary care provider up to once per month. For team care program recipients, a change of provider may be made in accordance with ARM 37.86.5303. The frequency of a recipient's request to change providers will be monitored by the department.

(6) Each enrollee in a household may choose a different primary care provider. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-113 and 53-6-116, MCA; NEW, 1992 MAR p. 2288, Eff. 10/16/92; AMD, 1996 MAR p. 2193, Eff. 8/9/96; AMD, 1997 MAR p. 2085, Eff. 11/18/97; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00; AMD, 2003 MAR p. 1203, Eff. 6/13/03; AMD, 2004 MAR p. 1624, Eff. 7/23/04.)

Rules 05 through 09 reserved

37.86.5110 PASSPORT TO HEALTH PROGRAM: SERVICES (1) An enrollee must obtain the services in (a), except as provided in (b), directly from or through authorization by the enrollee's primary care provider:

(a) medicaid services requiring authorization:

(i) inpatient hospital services as defined in ARM 37.86.2901;

(ii) surgery, physical therapy, occupational therapy, speech therapy, and home health services delivered as outpatient hospital services as defined in ARM 37.86.3001;

(iii) ambulatory surgical center services as defined in ARM 37.86.1401;

(iv) physician services as defined in ARM 37.86.101;

(v) federally qualified health center services as defined in ARM 37.86.4401;

(vi) rural health clinic services as defined in ARM 37.86.4401;

(vii) mid-level practitioner services as defined in ARM 37.86.202;

(viii) the following EPSDT services for enrollees under 21 years of age:

(A) screening services for children as defined in ARM 37.86.2005;

(B) chiropractic services as defined in ARM 37.86.2206;

(C) respiratory therapy as defined in ARM 37.86.2206;

(D) private duty nursing as defined in ARM 37.86.2206; and

(E) nutrition services as defined in ARM 37.86.2206.

(ix) physician services provided through a developmental diagnostic center as defined in ARM 37.86.1401;

(x) public health departments as defined in ARM 37.86.1401;

(xi) organ transplantation services as defined in ARM 37.86.4701;

(xii) physical therapy services as defined in ARM 37.86.601;

(xiii) occupational therapy services as defined in ARM 37.86.601;

(xiv) speech therapy services as defined in ARM 37.86.601;

(xv) home health services as defined in ARM 37.40.701;

(xvi) podiatry services as defined in ARM 37.86.501; and

(xvii) emergency room services for emergent conditions as defined in ARM 37.82.102(5).

(b) aspects of services listed in (1)(a) that do not require prior authorization by the enrollee's primary care provider:

(i) obstetrical services, both inpatient and outpatient;

(ii) inpatient and outpatient services for which the primary diagnosis is one of the following ICD-9 codes: 290 through 302, 306 through 314, or 316;

(iii) family planning services as defined in Social Security Act 1905(a)(4)(c);

(iv) anesthesiology services;

(v) radiology services;

(vi) pathology services;

(vii) ophthalmology services for medical conditions of the eye;

(viii) immunization;

(ix) testing and treatment for sexually transmitted diseases;

(x) testing for lead blood levels; and

(xi) dental, vision and hearing services portion of the screening services for children.

(2) The primary care provider's authorization is not required for any of the following medicaid services:

(a) swing bed hospital services as defined in ARM 37.40.401;

(b) podiatry services as defined in ARM 37.86.501;

(c) audiology services as defined in ARM 37.86.702;

(d) hearing aid services as defined in ARM 37.86.801;

(e) personal care services as defined in ARM 37.40.1101, except for personal care services as provided pursuant to ARM 37.86.2232;

(f) home dialysis services for end stage renal disease as defined in ARM 37.40.901;

(g) mental health center services as provided in ARM 37.88.901 and 37.88.905 through 37.88.907;

(h) family planning services provided by a local delegate agency of the department of public health and human services as defined in ARM 37.86.1701;

(i) licensed psychologists services provided in ARM 37.88.601, 37.88.605 and 37.88.606;

(j) licensed clinical social work services provided in ARM 37.88.201, 37.88.205 and 37.88.206;

(k) dental services as defined in ARM 37.86.1001;

(l) licensed professional counselor services provided in ARM 37.88.301, 37.88.305 and 37.88.306;

(m) outpatient drugs services as defined in ARM 37.86.1102;

(n) prosthetic devices, durable medical equipment and medical supplies as defined in ARM 37.86.1801;

(o) optometric services as defined in ARM 37.86.2001;

(p) eyeglasses as defined in ARM 37.86.2101;

(q) transportation and per diem as defined in ARM 37.86.2401;

(r) specialized nonemergency medical transportation as defined in ARM 37.86.2501;

(s) ambulance services as defined in ARM 37.86.2601;

(t) skilled care facility services as defined in ARM 37.50.105;

(u) intermediate care facility services as defined in ARM 37.40.106;

(v) institution for mental disease services as provided in ARM 37.88.1401, 37.88.1402, 37.88.1405, 37.88.1406, 37.88.1410, 37.88.1411 and 37.88.1420;

(w) home and community services as defined in ARM 37.40.1406;

(x) freestanding dialysis clinic for end stage renal disease services as defined in ARM 37.86.4201;

(y) case management services as defined in ARM 37.86.3305 et seq.;

(z) nonhospital laboratory and radiology (x-ray) as defined in ARM 37.86.3201;

(aa) admission for inpatient psychiatric services as provided in ARM 37.88.1101, 37.88.1105 through 37.88.1107, 37.88.1115 and 37.88.1116;

(ab) therapeutic youth group home or therapeutic youth family care services under the EPSDT program;

(ac) hospice as defined in ARM 37.40.801 and 37.40.806.

(ad) dietician as provided in ARM 37.40.1475; and

(ae) respiratory therapy as provided in ARM 37.40.1463.

(3) The requirement that services listed in (1)(a) be authorized by the primary care provider does not replace or eliminate other regulatory or statutory requirements for or limits on obtaining and being reimbursed for medicaid services.

(4) Nothing in this rule reduces or otherwise affects the requirements that must be met under ARM 37.88.101, to obtain or access mental health services as provided in this chapter. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-116, MCA; NEW, 1992 MAR p. 2288, Eff. 10/16/92; AMD, 1994 MAR p. 313, Eff. 2/11/94; AMD, 1994 MAR p. 2983, Eff. 11/11/94; AMD, 1996 MAR p. 2193, Eff. 8/9/96; AMD, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1997 MAR p. 1269, Eff. 7/22/97; AMD, 1997 MAR p. 2085, Eff. 11/18/97; AMD, 1998 MAR p. 2045, Eff. 7/31/98; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1338, Eff. 3/31/00; AMD, 2003 MAR p. 1203, Eff. 6/13/03.)

37.86.5111 PASSPORT TO HEALTH PROGRAM: PRIMARY CARE PROVIDERS REQUIREMENTS (1) A primary care provider must meet the following requirements:

(a) enroll as a medicaid provider;

(b) provide primary care; and

(c) sign a passport contract for primary care case management.

(2) A primary care provider may be subject to utilization review to determine that the care and services provided through the program are fulfilling the provisions of the primary care case management agreements with the program and are only those which are medically necessary or otherwise permissible. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, 53-6-116, MCA; NEW, 1992 MAR p. 2288, Eff. 10/16/92; AMD, 1994 MAR p. 313, Eff. 2/11/94; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00.)

37.86.5112 PASSPORT TO HEALTH PROGRAM: REIMBURSEMENT

(1) Reimbursement for primary care case management services is $3.00 a month for each enrollee.

(2) A primary care provider may be reimbursed for primary care case management for an enrollee for a month during which case management or medical care was not provided to the enrollee if the primary care provider is otherwise in compliance with the agreement with the program.

(3) Medicaid services authorized or provided by a primary care provider are reimbursed as provided in ARM Title 37, chapters 40, 82, 83, 85, 86, and 88.

(4) Services listed in ARM 37.86.5110(1) provided to enrollees are not reimbursable unless provided or authorized by an enrollee's primary care provider in accordance with these rules. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-116, MCA; NEW, 1992 MAR p. 2288, Eff. 10/16/92; AMD, 1996 MAR p. 2193, Eff. 8/9/96; TRANS, from SRS, 2000 MAR p. 481.)

Rules 13 through 19 reserved

37.86.5120 PASSPORT TO HEALTH PROGRAM: FAIR HEARING

(1) An enrollee or a provider has the right to appeal an adverse action in accordance with ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-116, MCA; NEW, 1992 MAR p. 2288, Eff. 10/16/92; AMD, 1996 MAR p. 2193, Eff. 8/9/96; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

Subchapter 52

Disease Management Program

37.86.5201 DISEASE MANAGEMENT PROGRAM: DEFINITIONS The following terms and definitions apply to the disease management program:

(1) "Disease management organization (DMO)" means a clinically qualified organization that has a disease management program which uses evidence based health care practices.

(2) "Disease management program services" means specialized services provided to medicaid clients with the chronic medical conditions listed in ARM 37.86.5205. Disease management program services are aimed at care coordination, client education, improved client self-care and efficiency and cost effectiveness of services.

(3) "Eligible client" means a Montana medicaid client who has the disease management program's specified combination of eligibility and disease factors.

(4) "Enrolled client" means an eligible client who has been notified in writing of enrollment in the disease management program and eligibility to receive disease management program services and who has not declined to participate.

(5) "Evidence based healthcare practice" means a clinical approach to practicing medicine based on the clinician's awareness of medical evidence and the strength of that evidence to support the management of a disease treatment process.

(6) "Medical home" means one provider or clinic who provides the majority of all ambulatory health care services to each client. This provider is the client's source for routine or preventive healthcare. (History: Sec. 53-6-101 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 2003 MAR p. 2892, Eff. 12/25/03.)

37.86.5202 DISEASE MANAGEMENT PROGRAM: GENERAL (1) The disease management program provides coordinated health care interventions and education for medicaid clients with the chronic medical conditions listed in ARM 37.86.5205. The purpose of the program is to provide and/or coordinate services that decrease utilization and cost while optimizing treatment and improving health outcomes for clients.

(2) A disease management program must include the following procedures:

(a) evaluate each enrolled client;

(b) prioritize disease management program services provided to an enrolled client based on the client's need or other criteria, as appropriate; and

(c) contact and coordinate with a department or department authorized case manager as appropriate for planned service delivery to an enrolled client.

(3) Disease management program services must provide one or more of the following to each enrolled client:

(a) assistance in establishing a medical home;

(b) educational materials;

(c) instruction regarding self-managing the targeted conditions;

(d) assessment of available services, equipment and supplies that might enhance the client's ability to manage the client's disease processes; or

(e) coordination with a department or department authorized case managers.

(4) Disease management program services do not:

(a) change the scope of services available to a client eligible under a Title XIX medicaid program;

(b) interfere with the relationship between an enrolled client and the client's chosen provider(s);

(c) duplicate case management activities available to a client in the client's community; or

(d) substitute for established activities that are available to a client and provided by programs administered through other department divisions or state agencies. (History: Sec. 53-6-101 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 2003 MAR p. 2892, Eff. 12/25/03.)

Rules 03 and 04 reserved

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37.86.5205 DISEASE MANAGEMENT PROGRAM: CLIENT ELIGIBILITY AND ASSIGNMENT (1) To receive disease management services an eligible client must be a recipient of Montana medicaid and be diagnosed with at least one of the following chronic medical conditions:

(a) asthma;

(b) diabetes;

(c) heart failure;

(d) chronic pain; or

(e) cancer.

(2) A client must not be:

(a) receiving mental health service plan (MHSP) benefits, specified low income medicare beneficiary (SLMB) benefits or qualified medicare beneficiary (QMB) benefits;

(b) residing in a nursing home or institutional setting for more than 30 days;

(c) receiving medicaid benefits through presumptive eligibility;

(d) eligible for third party coverage that provides disease management program services or requires administrative controls that would duplicate or interfere with Montana medicaid's disease management program; or

(e) receiving case management services that disease management program services would duplicate.

(3) A client meeting the eligibility requirements in this rule:

(a) is automatically enrolled in the disease management program;

(b) is notified of the enrollment in writing;

(c) may request a disenrollment at any time; and

(d) may request a re-enrollment at any time. (History: Sec. 53-6-101 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 2003 MAR p. 2892, Eff. 12/25/03.)

37.86.5206 DISEASE MANAGEMENT PROGRAM: SCOPE OF SERVICES AND REIMBURSEMENT (1) If a disease management program is provided by a DMO, the program must meet the following criteria:

(a) the program requirements stated in the contract between the department and the DMO must be fulfilled;

(b) the scope of practice must be appropriate for the provider of the health care service; and

(c) the DMO must comply with all other applicable state and federal requirements.

(2) Only a DMO contracted with the department may bill and be reimbursed for providing disease management services. Billing requirements and payment methodology will be described in a contract between the DMO and the department. (History: Sec. 53-6-101 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 2003 MAR p. 2892, Eff. 12/25/03.)

Subchapter 53

Passport to Health Team Care Program

Rules 01 and 02 reserved

37.86.5303 PASSPORT TO HEALTH'S TEAM CARE PROGRAM (1) A recipient may be subject to restrictions on, or prior approval for, physician related services, pharmacy services or any other services covered by the medicaid program if the department determines that the recipient's utilization of service is excessive, inappropriate, or fraudulent with respect to medical need.

(2) The restrictions described in (1) may be imposed if any of the following events occur:

(a) the recipient seeks medical services that are not medically necessary;

(b) there is multiple provider usage that results in the receipt of unnecessary services;

(c) there is repeated use of emergency rooms for routine medical services;

(d) there is unwarranted multiple pharmacy usage, indicated by the use of more than three pharmacies, that results in the receipt of unnecessary prescriptions;

(e) there is admission of or conviction for forgery of medicaid drug prescriptions by the recipient; or

(f) the recipient utilizes a medicaid card in any unlawful or fraudulent manner.

(3) The department will use payment records, reports from medical consultants, provider referrals or other pertinent recipient or service information, to determine if recipient overutilization, or other abuses, have occurred.

(4) A recipient's restriction does not apply to other members of the household.

(5) Restriction of medicaid services may include limiting a recipient to a designated provider or providers or requiring the recipient to obtain department approval to receive non-emergent services. A recipient with restricted services is participating in the team care program. Medicaid payment for medical services provided to a team care participant will only be made to the recipient's designated provider(s) except:

(a) when emergency services, as defined at ARM 37.82.102(11), are required;

(b) when the designated provider refers the recipient to another provider; or

(c) when the department approved the service prior to performance.

(6) A recipient restricted to the team care program is required to participate in the passport to health program set forth in this subchapter unless the recipient is ineligible, as that term is defined in ARM 37.86.5102.

(7) A recipient whose medical service usage meets the criteria for restriction listed in (2), but who is ineligible for the passport to health program for the reasons listed in ARM 37.86.5102, may be required to participate in the team care program. A recipient living in a nursing home or institutional setting or a recipient whose eligibility period is only retroactive cannot be required to participate in either the passport for health or the team care programs.

(8) The department will notify a recipient in writing at least 10 days prior to the date of the intended action restricting medical services paid by the medicaid program.

(9) The department will determine the provider type to which the recipient is restricted (pharmacy, physical health provider or both). The recipient will have an opportunity to choose the recipient's primary care provider and pharmacy unless:

(a) the department determines that the selected provider has been sanctioned by the department in accordance with ARM 37.85.501;

(b) the designated review organization has determined that the selected provider has not properly managed the medical care of a recipient who has been restricted; or

(c) the selected provider will not accept the recipient as a patient.

(10) The recipient will have 10 days from the date of notification of restriction by the department to choose a primary care provider and a pharmacy provider. If the recipient does not choose a primary care provider and a pharmacy provider within 10 days, a primary care provider and a pharmacy will be selected for the recipient. If the department is unable to obtain a primary provider for the restricted recipient, all non-emergency services must be prior authorized by the department.

(11) A restricted recipient may request a change of provider. The request must be in writing and submitted to the department for approval. Provider changes will not be approved unless the department determines that there is good cause for the requested provider change. The department will have 30 days to take action on the request.

(12) The department will review all restricted recipients annually unless the recipient's medical service usage indicates an earlier review should occur. Restriction may be continued if:

(a) the department determines the recipient's use of services has remained excessive or unnecessary. Examples of excessive or unnecessary usage include, but are not limited to, those listed in (2);

(b) the designated provider recommends, with supporting rationale, that the recipient should remain restricted; or

(c) the recipient has received or attempted to receive medicaid services not authorized under the restricted card program.

(13) A recipient aggrieved by an adverse departmental action under this rule may request a fair hearing in accordance with ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337. (History: Sec. 53-6-113, MCA;
IMP, Sec. 53-6-104 and 53-6-113, MCA; NEW, 2004 MAR p. 1624, Eff. 7/23/04.)

Rules 04 and 05 reserved

37.86.5306 TEAM CARE PROGRAM: REIMBURSEMENT

(1) Reimbursement for team care case management services is $6.00 a month for each enrollee.

(2) A provider may be reimbursed for team care case management for an enrollee for a month during which case management or medical care was not provided to the enrollee if the primary care provider is otherwise in compliance with the agreement with the program.

(3) Medicaid services authorized or provided by a primary care provider are reimbursed as provided in ARM Title 37, chapters 40, 82, 83, 85, 86 and 88.

(4) Services listed in ARM 37.86.5110(1) provided to enrollees are not reimbursable unless provided or authorized by an enrollee's primary care provider in accordance with these rules. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-104 and 53-6-113, MCA; NEW, 2004 MAR p. 1624, Eff. 7/23/04.)

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